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Report of HJR 18 Study Committee

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REPORT OF

HJR 18

STUDY COMMITTEE

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REPORT OF

HJR 18

STUDY COMMITTEE

Prepared for:

44th Session
Montana State Legislature

1973 - 1974

Comprehensive Health Planning Office
State Department of Health
and Environmental Sciences
Helena, Montana 59601

September, 1974

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LETTER OF TRANSMITTAL

September 4, 1974

Dear Legislator:

A study committee composed of public health providers, consumers, and legislators spent considerable time, many words and little money philosophizing about the components of health care versus illness care; about health care services needed by people and which of these services should be financed with public funds; and about the role of state government in making public health services available to the people of Montana. The description of the committee's work and its analysis of data collected over the past two years make up the following report.

House Joint Resolution 18, passed by the 1973 legislative body, was the impetus for the committee's search for information: 1. to define minimum public health services; 2. to consider more effective structural arrangements for the provision of such services; and 3. to determine the most economical means for accomplishing the task.

All of the members devoted time to the HJR 18 committee work as other full-time jobs permitted, and the committee had no paid staff except for clerical assistance given by various Bureaus of the State Department of Health and Environmental Sciences. Dennis Taylor, an ACTION worker assigned to the Department's Division of Comprehensive Health Planning, coordinated the activities of the sub-committee which conducted interviews around the state and deserves a great deal of credit for the vital, catalytic role he played in meetings of the entire committee.

We in no way regard our study as an exhaustive one on the subject matter assigned but doubt that a more definitive research approach would uncover any different findings.

In this report we make a case for multi-county health departments, situated throughout the state, responsible for providing minimum public health services to be financed from state funds. Priority attention was given to defining minimum public health services and identifying minimum staff needed to provide such services as equitably as possible throughout the state. It was the committee's premise that once minimum public health services were defined, these could be implemented through whatever structural arrangements and financial mechanisms might evolve in counties or combinations of counties from the planning efforts of other state departments or the State Commission on Local Government.

Special attention is directed to pages 31-34, the summary findings of sub-committees, and the committee's recommendations which follow this letter.

Committee members view the accompanying report as merely the first step toward improving the quality, quantity, and availability of public health services in Montana. We realize that making changes structurally, either at the state level or county levels to facilitate the provision of public health services, is a much simpler task than changing attitudes about the need for and value of such services. There is some comfort, however, in believing that the recommendations of this committee can compliment and supplement statewide and national planning directed toward making truly comprehensive health services available to all people. The committee plans to stay intact to assist in preparing, interpreting, and promoting legislation directed toward implementation of its recommendations.

Your support for the committee's recommendations is appreciated.

Sincerely,

HJR Study Committee
Mary D. Munger, Chairperson

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HJR 18 RECOMMENDATIONS

Recommendation #1

I. The acceptable minimum level of services to be provided by a local public health unit in Montana must include:

A. Community Health Services

1. The local health department should and must serve as the diagnostician of the community as a whole; must serve as the community catalyst and bridge between the public with the need and the complex of the community's health resources with the solution.[1] To accomplish these tasks requires a network of effective alliances with individuals, groups, and agencies for:

a. Generating, collecting, coordinating, analyzing and disseminating health program data and information;

b. Critically assessing present and potential community health problems and factors in other fields that may relate to or effect them;

c. Establishing community health policy and standards as necessary;

d. Stimulating action by whoever may be of assistance, whether governmental or non-governmental institutions;

e. Promoting necessary health legislation;

f. Evaluating what is done.

B. Preventative Health Services

1. Major emphasis must be placed upon early detection and treatment aimed at circumventing the progressive development of disease--primary prevention, health maintenance and health promotion. These services can be provided through:

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[1] "Is There a Future for Local Health Departments?" - John J. Hanlon, MD, Appendix H, pages H65-H68.

a. Education and counseling about health and illness;

b. Complying with state standards regarding communicable disease control; providing facilities for examination, treatment and follow-up of suspected communicable disease as well as providing appropriate immunizations;

c. Screening programs such as vision, hearing, blood pressure measurement, dental hygiene, etc.;

d. Home care services;

e. Education of the public, professions, business and industry, elected officials and others in the fundamentals of community health.

C. Environmental Health Services

1. Although the issues affecting the environment extend beyond the health system, local health departments must employ qualified staff to:

a. Assure safe drinking water and adequate sewage and solid waste disposals;

b. Enforce state and local standards to reduce air and water pollution;

c. Enforce state and local sanitary standards for public facilities such as restaurants, hotels, motels and trailer courts;

d. Enforce state and local standards as required for occupational health and safety;

e. Arrange educational programs regarding injury control;

f. Insure adequate input concerning protection of the public health as it relates to land development and housing;

g. Assure safe and wholesome food through inspection and laboratory analysis of storage, manufacturing and distribution sources.

Recommendation #2

II. The acceptable minimum level of staffing for local public health units is based on the experience of public health providers in Montana and are adapted from recommendations of the American Public Health Association.

A. Health Officer/Administrator (Doctor of medicine degree with public health experience or a masters in public health. If the Health Officer/Administrator does not hold a doctor of medicine degree, those services requiring a physician should be contracted out and the State Department of Health and Environmental Sciences would need to be assured that the medical aspects of the public health program are being conducted under the supervision of a competent physician.) --one per local health unit.

B. Public Health Nurses -- one per 4,000 population. (If the Department is authorized to provide direct care to ill or convalescing people at home, the recommended ratio is one public health nurse for every 2,500 population.)

C. Nursing Supervisor -- at least one per local public health unit.

D. Sanitarians -- one per 10,000 population plus necessary sanitarian supervisory personnel.

E. Health Educators -- at least one per local public health unit.

F. Dental Hygienist/Dentist -- at least one per local public health unit.

G. Clerical Support

H. Outreach Workers

III. The State Department of Health and Environmental Sciences must have statutory authority: 1. To require that local public health units are organized, financed, and staffed to provide the recommended minimum services listed under recommendation #1; and 2. To transfer as many functions as possible to local public health units. Toward this end there is need to:

A. Request a legislator to ask Montana's Legislative Council to conduct a search of Montana's statutes for all laws pertaining to the functions and authority of the State Department of Health and Environmental Sciences to determine its authority to require local governments to provide minimum public health services; and to determine its authority to make joint financial arrangements with local public health units.

B. Request a legislator to prepare and introduce legislation to give the State Department of Health and Environmental Sciences the authority described in Item A with concomitant funding.

1. There is an ongoing analysis of the current amount of money being spent on public health services within Montana from federal, state and local sources. This analysis will be the basis for the fiscal request attached to the legislation described in the above paragraph.

C. Retain in state law the authority of the State Department to:

1. Adopt state regulations where needed in the interest of protecting public health and oversee enforcement;
2. Set standards for all public health services and oversee enforcement;
3. Supplement all laboratory, environmental health services, nursing and health education not available through local public health units.

Recommendation #4

IV. The State should provide funds to the State Department of Health and Environmental Sciences to stimulate the development of local public health units which will have the capability of providing the minimum services defined in Recommendation #1. The State Department of Health and Environmental Sciences and other appropriate state agencies should assist counties or groups of counties explore all sources of revenue for local public health services to guarantee a predictable financial base and a workable incentive formula. Criteria for determining the allocation of state funds should include:

A. Working with officials of an approved multi-county government structure;

B. Incentives for the sharing of state resources by multi-county public health units such as:

1. An equal base amount for each county;
2. A standard per capita amount for each county;
3. An incentive bonus for each county with a multi-county public health unit (possibly double the amount under items 1 and 2);
4. An additional incentive bonus for multi-county public health units that conform to one of the twelve Governor-approved multi-county districts.

C. Consideration of the amount of money spent by each county on a per capita basis for public health services during the latest fiscal year and the source of the money. Money for local public health services have traditionally come from a variety of sources: General county funds, special county health funds raised by levying an ad valorem tax of 1/2 to 1 mill; contributions from cities of first, second and third class; revenue sharing funds; local boards of

education; fees for service; community chest or united community services funds and grant-in-aid programs administered by the Department of Health and Environmental Sciences.

Recommendation #5

V. The State Commission on Local Government has received a grant to study the delivery of public health services by local government which this committee views timely and the next logical step in implementing its recommendations. Therefore, it is recommended that:

A. The recommendations of the HJR 18 Study Committee be promoted by the State Commission on Local Government as it attempts to create a multi-county health district;

B. That the above request be forwarded to Governor Thomas Judge; and

C. That members of the HJR 18 Study Committee be invited to serve on any task force the State Commission on Local Government establishes relative to public health services.

REPORT OF COMMITTEE TO IMPLEMENT
HOUSE JOINT RESOLUTION 18

Introduction

Concern about the lack and maldistribution of public health services in Montana motivated a task force of the State's Comprehensive Health Planning agency to request a statewide study. The result of the agency's concern was House Joint Resolution 18 which was passed by the 1973 Montana Legislature and which requested the Legislative Council, with the assistance of the Department of Health and Environmental Sciences, to conduct a study "to determine an acceptable minimum level of services to be provided by county and city-county health departments, to determine the feasibility of creating district public health departments, and to recommend the most economical means for accomplishing this task."[2] The Legislative Council selected the study as one of three priorities and assigned it to the interim joint Public Health, Welfare and Safety Committee for implementation.

A nucleus committee composed of eight people, all staff members of the State Department of Health and Environmental Sciences, held two meetings in April, 1973, to analyze the intent and ramifications of the resolution and to develop a plan for its implementation.

The study design for HJR 18[3] evolved from the many discussions and debates provoked by the following questions:

> What are minimal public health services?
>
> What public health services are currently available either from state or local sources?

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[2] Copy of HJR 18 - Appendix A, pages A1-A2.

[3] Copy of HJR 18 Study Design - Appendix B, pages B3-B4.

Should the State Department of Health and Environmental Sciences be decentralized and regionalized to better serve the State and make better and more efficient use of personnel and services?

Should the Department of Health and Environmental Sciences be involved in providing direct services to local communities or should State efforts be directed toward generating needed services within local communities?

How are public health services financed and how do the financing mechanisms influence the health program focus and the scope of the health program?

Does the average citizen know what public health services are or are not available?

How does the public feel about existing public health services? What public health services is the public willing to finance?

How are public health needs identified?

The Study Plan

At the June, 1973, meeting of the Joint Interim Legislative Committee on Public Health, Welfare and Safety, staff members from the State Department of Health and Environmental Sciences reported on services provided through the State agency[4] and proposed a five-phase study plan on which to base recommendations as requested under HJR 18. Health services financed through a public source which focus on control of communicable disease and the promotion of health habits which keep people well or health services which stress prevention of illness and maintenance of health were classified as traditional public health services. The Legislative Committee approved the study plan with the recommendation "to limit the study to the availability and provision of 'traditional' services by public health departments, and to concentrate on the

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[4]Materials presented to Legislative Committee, 6/73 - Appendix C, pages C5-C33.

feasibility of a district structure through which to provide public health services."

From June, 1973, to October, 1973,[5] when a follow-up report was presented to the Joint Legislative Committee, the original committee of eight staff members of the State Department of Health and Environmental Sciences had been enlarged to a total of 21 members.[6] Ten of the committee members represented bureaus within the State Department of Health and Environmental Sciences; two were full-time health officers of local city-county health departments; there was a public health nurse from a local area, one outreach worker, one State Senator, two State Representatives, and three consumers.

Three subcommittees made up of members of the larger committee activated and completed the first three steps of the study plan. Methods used by the subcommittees to collect data and a summary of each subcommittee's general findings are detailed in the next portion of this report.

Information collected by the three subcommittees became the data base from which the full committee made its recommendations thereby completing step four of the study plan.

Interpreting the committee's findings to the public in the hope of gaining public support for the concepts proposed and for recommended legislation will complete the fifth and final phase of the study plan.

Two bureaus of the State Department of Health have borne the expense of the committee's work to date which has included paper, postage, secretarial services, and some mileage and per diem reimbursement for the three

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[5]October, 1973, Legislative Report - Appendix D, pages D34-D36.

[6]List of Committee Members - page 3-4.

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consumer-legislator teams. Local agencies paid expenses of committee members to attend meetings in Helena.

During the synthesis phase, step four, of the HJR 18 study, it became apparent to committee members that any recommendations regarding the delivery of public health services must be adaptable to possible changes in local governmental structures or to any plan which proposes the coordination of human services at State or local levels.

Step 1 -- Definition of the Present

Data Collection Methods

The subcommittee assigned to activate step one of the study design was asked to delineate traditional public health services currently available throughout the State provided either by the State Health Department or at the city or county levels. Reports from State Health Department personnel which were presented to the Interim Legislative Committee in June, 1973, detail the number of nurses and sanitarians employed throughout the State and describe the type and variety of services provided. The June, 1973, legislative report also attempted to distinguish services provided only by the State Health Department from those which are delivered through local public health personnel in collaboration with State Health Department personnel.

To assess the general public's perception of public health services currently available, and ideas about what services should be available, and how such services should be financed, two people from three geographic areas of the State conducted field interviews. Each team composed of a State legislator and a consumer studied a county with many public health services available through a somewhat coordinated system, a county with fragmented services and a county with minimal or no services. A list of individuals to contact in each county and a list of basic questions to be asked were prepared in advance by the interviewers and members of the HJR 18 Committee.[7]

In reporting on their work the field teams tried to include both subjective and objective information gleaned from on-site study and observation.

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[7]Format of questions and contacts used by interview teams --- Appendix E, pages E37-E39.

General Findings

The attached map[8] depicts the present structural arrangement of the State Department of Health and Environmental Sciences. No attempt was made to examine the services provided through each division and constituent bureau of the Department. Close attention was paid, however, to those State services which touch most Montana communities and which fit more easily under the classification of "traditional" public health services. A brief description of each service follows.

State Services

ENVIRONMENTAL

The Environmental Services Bureau of the State Health Department has responsibility for the control of air and water pollution, solid waste disposal, food and drug control, public accommodations licensing and control, pesticides, vector control, subdivision control, and public swimming pool control. All State environmental control programs are dependent upon local health department support and activities. Local sanitarians extend State programs to the field level and are employed under several different arrangements. Sanitarians are employed by cities, combinations of city and county, or combinations of counties.

NURSING

Nurses employed by health departments or single counties to provide public health services are assisted in their efforts by nursing consultants employed by the Bureau of Nursing of the State Department of Health and Environmental Sciences. Nursing activities vary from county to county depending on the educational preparation of the nurse and the expectations of the employer. The public health nurse is involved with primary, secondary, and tertiary preventative measures. Control of communicable disease through

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[8]Appendix C, page C10.

immunization programs, information about family planning, and education for parenthood classes are examples of primary preventive measures. Identifying problems which represent a deviation from normal physical or mental health, assisting individuals or families obtain suitable care and treatment as early as possible, and reinforcing those health habits most likely to assure a satisfactory level of wellness fit under secondary and tertiary preventative measures. The nurse works with others in the community served for the elimination of health hazards, and for the accessibility of medical, health, and social services within the community.

HEALTH EDUCATION

The Health Education Bureau of the State Health Department assists other bureaus and divisions of the Department in (a) developing and implementing health education programs, (b) community organization, (c) developing educational aids, (d) disseminating information about health matters, or (e) conducting educational programs. Currently, the Missoula and Cascade County Health Departments employ the services of a full-time health educator, the only local one in the State.

LABORATORY

The Laboratory Division of the Department of Health and Environmental Sciences, through its two Bureaus conducts chemical and microbiological analysis of air, water, food, blood, urine, or feces, to assist in environmental control and early diagnosis of suspected communicable disease. The State Laboratory serves also as a reference lab for difficult and unusual laboratory procedures and helps improve the performance of hospital and private laboratories around the State through proficiency testing. Missoula's health department operates its own laboratory offering a wide range of chemical and environmental health services.

Local Services

Attached maps[9] show the location of Montana's three full-time health departments (a central agency with a city-county board of health coordinated by a full-time health officer with an employed staff of public health nurses and sanitarians) and the location of sanitarians and public health nurses. As can be seen from the maps, there is no uniformity in the local public health services available to the residents of Montana's 56 counties. The activities, staffing patterns, funding levels and funding sources vary greatly between the three full-time health departments. However, each health department provides a wide range of public health services, from dental screening to home health nursing, while the majority of the other counties in the state provide minimal services.

The local health board and the local health officer are only nominal entities in most counties. Although Montana law requires the appointment of local health officers, most serve in a part-time capacity. The part-time local health officer is concerned primarily with providing medical services for private patients, and is thereby unable to devote sufficient attention to health officer responsibilities.

The most striking and persistent reality uncovered by the interview teams is the low priority given public health needs in competition with other community needs. As one interviewer put the situation, "County health officers of all counties seem to be at the bottom of the totem pole as far as County Commissioners' concern and help is needed."

Another significant problem noted in all counties studied, regardless of the level of public health provided in that county, is the low, in some cases almost nonexistent, awareness of the value of public health services

[9]Appendix C, pages C10 and C21.

by the ordinary citizen and by the elected or appointed officials charged with health decision making on the local level. One interviewer observed, "It would appear to me from talking to the providers, County Commissioners, etc., that public health services are being provided satisfactorily, but the lack of knowledge about this subject by the ordinary citizen is very apparent. In fact they know nothing about the program and with rare exceptions it does not seem to bother them. They seem to believe this is someone's responsibility but does not concern them." Another interviewer expressed the feeling that "most citizens who are not involved in providing the services, or are not associated with some local government position, were completely unfamiliar with the services, and didn't have much of an idea of what they would like to see in the future."

The low level of State and local support of public health services was a problem noted in every area studied by those people who were aware of health services. The public health personnel, especially in counties with minimal or fragmented services, "only have so much time and cover a lot of area so they are not always available . . . ." The inaccessibility of services, compounded by serious transportation problems in most areas of the State pointed up the need for greater emphasis on "outreach" and consolidation of services so that "the people can benefit from all types of services at one site." It was recommended that city and county health boards in most counties need "better public relations in order to inform the community of the services they provide."

Traditional political boundaries continue to dominate as the primary consideration in determining a geographic base for public health services. Despite moves by the past two State administrations to encourage the creation of district or multi-county organizations for planning purposes and for the delivery of more comprehensive services, there exists great reluctance to

consolidate and an innate opposition to any new concept that appears to threaten existing political jurisdiction or erode local power. Despite the fact that most counties lack the financial capacity to provide comprehensive, "traditional" public health services, most appear reluctant to develop a regional approach for the delivery of such services. There seems to be either a general satisfaction with existing services, however minimal, or a desire to have the State play a greater role in financing operations as long as existing political jurisdictions on the local level are respected. This continued "territory guarding" by local political jurisdictions is seen as a serious roadblock to any significant change in the delivery of public health services in Montana.

Most people who were aware of public health services and their relative value felt that a gradual building of an integrated public health program that will provide comprehensive public health services of optimum quality, equally available and accessible to all Montanans is necessary. It was felt by many people interviewed that the State should assure every community of coverage by an official health agency and access to the complete range of public health services. There seems to be a need to stimulate and support the development of local health units that will provide the necessary public health services to local communities. The consensus was that financial support for local health units must be expanded. Although most people felt that financing should come from State or federal sources, they agreed that the State should delegate as many of its functions to the local health unit as can be properly and effectively carried out. It would appear that increased State aid should contain financial incentives for any necessary reform in the structure and organization of local public health agencies to attempt to overcome the resistance of "territory guarding."

Step 2 -- Indication of Needs

Step 2 Sub-Committee, composed of two local health officers, a local public health nurse, an outreach worker, and the Chief, Bureau of Records and Statistics, State Dept. of Health and Environmental Sciences, was charged with defining the indices to be used in planning for health districts or health regions.

With statistical information provided by the Bureau of Records and Statistics and the Information System Bureau of the Department of Intergovernmental Relations the Study Committee began its analysis and completed its selection.

The indices selected fit under three general categories: 1) Health Status Indicators; 2) Health Resources Indicators; and 3) Social and Political Indices.

Each of the following maps[10] graphs a specific index and the rationale for each choice is explained below.

I. Health Status Indicators

Map 1 -- Population of Montana Counties, 1970 Census

Map 2 -- Population Density, Montana Counties, 1970

Maps 1 and 2 both indicate where the people are in the State and, because public health services are people-oriented, both maps aid in defining natural service clusters. Map 2, additionally, dramatizes the wide range of population densities in Montana, from 0.4 to 58.7 people per square mile. Obviously, the cost of delivering a person-oriented service is highly dependent upon accessibility to people which is easiest in highly dense populations. Only six of Montana's 56 counties have more than 10 people per square mile.

Map 3 -- Percent Change of Population, Montana Counties, 1970-72

Although the base data for Map 3 is estimated for 1973 from vital statistics and school records, it still fairly reliably indicates the

[10] 23 Maps - Appendix F, pages F40-F62.

counties with the greatest population growth pressures. A rapidly increasing population creates special problems in environmental health, especially subdivision, water, sewage and solid waste control, and increases demands for school health and maternal and child health public health nursing services. Conversely, a decreasing population usually indicates that only the aged are remaining and the area will have difficulty attracting young health service personnel; therefore, there is greater demand for Home Health Nursing Services.

Map 4 -- Age-Adjusted Death Rates, Montana Counties, 1969-71

The most important single variable affecting the number of deaths in a population is its age distribution. Obviously, a county with a high proportion of older individuals will exhibit a higher crude death rate than will one with a younger population, other factors being equal. Age-adjusted death rates remove the age factor from consideration and show the rates that would have been obtained had each county had the same age distribution as the entire State. These age-adjusted death rates then reflect the remaining factors such as the sexual distribution, ethnic variations and the level of medical care. Age-adjusted death rates can be computed accurately only in those years surrounding a census year when reliable information regarding the age distribution of the population is available.

Map 5 -- Five-Year Age-Adjusted Resident Death Rates for Selected Causes, Montana, 1968-72

Map 5 shows age-adjusted resident death rates for heart, cancer and stroke combined. These are the three major causes of death in Montana, and together account for over half of all deaths. Public health can play an important role in reducing them through health education for personal preventive practices and screening programs.

Map 6 -- Five-Year Death Rates for All Accidents, Montana Counties, 1968-1972 (By Place of Occurrence)

Map 6 shows the relative accidental death rates. Accidents are the leading cause of death between the ages of 1 to 40 and the absolute leading cause of lost productivity years through disability and death in Montana. Public health services can play a role in reducing accidents primarily through health education and improvement of safety standards and emergency medical services.

Map 7 -- Five-Year Death Rates for Cancer of the Uterus, Montana Counties, 1968-1972 (By Place of Residence)

Map 7 shows uterine cancer death rates; however, as it is not age-adjusted, it probably most reflects age distribution, as cancer increases with age. It also reflects the availability and utilization of uterine cancer screening (pap smear) services, as early diagnosed uterine cancer has a high cure rate.

Map 8 -- Neonatal Mortality Rate

Because of the difficulties in making exact estimates of the infant population, the infant mortality rate is universally taken simply as the ratio of infant deaths during a given year to the recorded births for the same calendar period.

According to Wilson G. Smillie in Preventive Medicine and Public Health: "The infant mortality rate is the most delicate and most important index of the degree of the sound development, and the measure of the cultural level of any community." Benjamin in his book Elements of Vital Statistics has a fairly lengthy discussion of the subject which may be summarized as: "It is not surprising that infant mortality has been found to be a sensitive index of the general living of the community, and of the efficacy of public health measures to mitigate the effects of the existing social conditions."

Map 8 reflects the level of personal health care received by mothers during the prenatal period, labor and delivery, and by the infants during the first month of life. It is the responsibility of public health to assure that adequate services of this type are available to all citizens.

Map 9 -- Post-Neonatal Mortality Rate

Map 9 reflects the living conditions in the home during the infant's first year of life, including nutrition, shelter, preventive and curative medical care, and most importantly, maternal and paternal competency and concern. Public health services have essential responsibilities to improve post-neonatal mortality rates through health education, counseling, service and intervention.

2. Health Resources Indicators

Personnel Distribution

Map 10 -- Population per Licensed Medical Professional, Montana Counties

For Map 10 Licensed Medical Professionals include: physicians, osteopaths, dentists, optometrists, registered nurses, pharmacists, psychologists, and licensed practical nurses.

Map 11 -- Population per Licensed Hospital and Nursing Home Bed, Montana Counties

Maps 10 and 11 both show the relative availability of personal, private health care resources to people. In these maps, a low number (low quartile) is optimum. However, the greatest need for direct public health services will be in those counties with high numbers (high quartile).

Map 12 -- Population per Community Health Nurse, Montana Counties, 1972

Map 13 -- Population per Sanitarian, Montana Counties, 1972

Both of these maps, Maps 12 and 13, indicate the present level of the counties' public health services. A blank spot means there

are no services available. The high quartile counties have the lowest level of services. These maps reflect the present local governments' concern for providing public health services.

Other Public Health Resources

Map 14 -- Percent of Population with Approved Refuse Disposal, Montana Counties

Map 14 reflects the counties' concern to protect the environment.

Map 15 -- Percent of Population on Approved Community Water Supply, Montana Counties

Map 15 reflects both the population distribution within the counties (urban or rural) as community water supplies can only be developed where the population is sufficiently dense, and there is awareness of the value of safe drinking water.

Financial Resources Distribution

Map 16 -- Median Family Income, Montana Counties, 1969

Map 17 -- Per Capita Income, Montana Counties, 1969

Maps 16 and 17 show the relative wealth of individuals among the counties. Therefore, it provides some index of their population's own ability to purchase preventive and curative health care services. It also shows the probable need for the services as the need increases with decreasing wealth.

Ideally, ranking of "Median Family Income" (Map 16) and "Per Capita Income" (Map 17) should agree. However, if the ranking of "Median Family Income" is substantially lower than the ranking of "Per Capita Income," then it indicates a relatively few individuals are very wealthy, but that the average family is poor (Madison County).

Map 18 -- Taxable Valuation Per Capita, Montana Counties

This map indicates the relative financial resources available to local governments to support public health activities. Fortunately, in many cases low population density (expensive cost of delivery of services) coincides with high taxable valuation (availability of local funds).

3. Social and Political Indices

Map 19 -- Administrative Districts and Regions

Map 20 -- Commerce Catchment Areas

Map 21 -- Montana Legislative Districts

Map 22 -- Comprehensive Health Planning Areawide Agencies

Map 23 -- Mental Health Center Districts

Step 3 -- A Comparison of Structural and Process Approaches

A five-member sub-committee analyzed information obtained from 15 states about the type of structural arrangement in the state for delivering public health services as well as the scope of the services offered. Information was generated from at least three additional states which operate under a district or regional arrangement.

Tabulation of responses to the questionnaire,[11] which follows, was interesting but the committee concluded there was no one state plan it would recommend at this time. It was also the committee's belief that most states are not much further advanced in studying a better method of providing local health services than is Montana.

Questionnaire -- Local Public Health Services

What public health services are offered by local health departments in your state? Also, please indicate which, if any, are mandated by law.

ENVIRONMENTAL		HEALTH EDUCATION	14
Air	11	FAMILY PLANNING	14
Water Pollution	11	HOME HEALTH CARE	14
Solid Waste	11	MENTAL HEALTH	12
Occupational Health	10	IMMUNIZATION	14
Food Establishments	12	WELL CHILD CLINICS	14
Institutions	10	SCHOOL HEALTH	10
Vector	11	OTHER	3-Screening

How are local public health services provided in your state?

City Health Departments	7
County Health Departments	10
District Health Departments	4
A Combination of the Above	8
State District Units	2

Are local public health services combined with other public services (such as social services) at any location in your state?

Yes 6 No 9

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[11] List of states to which questionnaires were sent with states responding noted - Appendix G, page 64.

If yes, please list these other services:

Arkansas: Health/Mental Health/SRS
Utah: Welfare/Mental Health/Corrections/Education
Oregon: County Human Resources Dept.
California: Co. Hospital Services/Public Assistance/Mental Health/Drug/Alcoholism
Washington: Social Services Division/Mental Health/Alcoholism

What state agencies are involved with the delivery of these other services?

See above.

Do you consider the integration of local public health services with other social services to be an efficient means of providing public health service delivery?

Yes 8 No 6

If no, please explain:

Population distribution
Mental health/physical health problems too similar
Funding problems
Confusion over responsibility for client

If you have district health departments anywhere in your state, answers to the following questions would be appreciated:

Do your local health services receive support from more than one source (percentage of amounts, if known)?

Local funds 7
State funds 9
Federal funds 8
Other 1-Private

Wide Variation of Amounts

Does a state agency have control over the local units?

Yes 5 No 6

If yes, what is the name of the state agency or agencies?

Public Health Departments - 4

How is state control maintained? Is it through (check as many as apply):

		Examples:
Budgets Grant, contracts, etc.	11	
Programming	7	Provision for disbandment of board
Personnel Classification & Employment	10	Contracts to accept consultation and maintain standards
Providing Consultation	9	District controls local and state controls district
Supervision by Law	9	

(Continued)

Records & Reporting 8

Assignment of State Staff to Local Units 6

Other 0

If local health services programs are controlled primarily from local level, what type of organization is involved?

County boards of health (10)
Multi-county boards of health
County boards of health with advisory committee

What do you consider to have been the major facilitators of a successful public health service delivery program in your state? (Not prioritized)

Local public health nurses
Consultation and direct service from state health department
Public interest and support
Community education
Home health care
Family planning
Rising costs of health care
Loss of physicians in rural areas
More qualified nurses
State law and funding
Federal funding (314d) - 4

What do you consider to have been the major inhibitors? (Not prioritized)

Lack of funds - 8
Emphasis on brick and mortar
Vested interests
Political opposition
Small population
Manpower problems
Strong sense of independence in population
Shortage of practicing physicians
Lack of community interest
Lack of clear definition of responsibilities

Do you feel the "district" method is more efficient than any previously used? (Are you reaching more people with better services?)

Yes - 7

Any additional comments:

Only three additional comments:

Kansas: "I have erased the term 'district' as it can be taken 2 ways. Either it is a state or local unit. The term 'local multi-county' emphasizes that the services are under local control and not state."

Washington: " 'Districts' seem to have more equitable representation on Boards of Health and a better mechanism for provision of local tax funds, but this is a very subjective judgement (sic) on my part."

Texas: " 'Districts' are desirable and more will be established. 81% of the population of Texas is covered by state participating local health departments."

As can be determined from a review of the tabulations, there is no consistency in the responses. For example, in answer to the question of the efficiency of combining health services with other social services, 8 states checked "yes" and 6 checked "no"; and yet only six of the states indicate experience with combined public health/social services.

There was no common definition of a district health structure which troubled three states. Four states indicated they had district health departments while seven states favored the district method as being more efficient.

Ten of the 15 states have county health departments with county boards of health similar to those in Montana.

Step 4 -- Synthesis

Summary Findings -- Step I

1. There is a consistent low priority given public health services by the majority of Montana's counties.
2. County Commissioners, generally, give public health services low priority in budget planning.
3. There is a lack of awareness on the part of public health providers, locally-elected officials and other local service representatives about the type and content of public health services currently available or what might be available.
4. There is too little integration of public health services which are provided at the local level and those provided at the State level.
5. There is a lack of available and uniform funding for public health services at the local level.
6. There is a need for knowledgeable and cooperative public health service decision makers.
7. There is a need for more cooperation and integration between the public health service system and the private health care system.
8. There is a need to involve more people, particularly consumers, in discussions and decisions about public health needs and programs.
9. Public health personnel are most often identified only with enforcement of laws or ordinances which overshadow their educational, consultative role.
10. Public health services at the local level are too dependent on local funds.

11. There is not enough effort made by existing public health agencies to utilize the outreach concept in informing people about available services or to provide services in isolated areas.
12. Counties and local governments appear to be resisting the concept of forming multi-county districts.
13. The State should coordinate more effectively services for people as provided by the State Department of Social and Rehabilitation Services, the State Department of Institutions and the State Department of Health and Environmental Sciences.
14. The Department of Health and Environmental Sciences should initiate a more aggressive facilitator role in assisting local communities to provide public health services.
15. There is no uniformity in the amount and kind of public health services available in Montana counties.
16. State funds are needed to provide a minimum level of public health services statewide through mechanisms which will assure local control over the planning and provision of such services.

Summary Findings -- Step 2

Health Status Indicators:

1. The wide range of population densities from 0.4 to 58.7 per square mile supports the need for regional or district health departments, and can be used in determining the type of health services needed in an area. As a rule, older people tend to live in the rural, sparsely populated parts of the State and have special health needs.
2. Public health services need to be designed to reflect population changes. Where the population is increasing, more attention must be

given to maternal and child health services which include school health while a decreasing population finds older citizens in need of such services as home health care.

3. In those counties where the age-adjusted death rates for heart disease, cancer and stroke are in the high quartile, there is need for health education about the prevention, early detection and treatment of these diseases.
4. Counties with a high accidental death rate need to examine the availability and quality of emergency services as well as providing educational programs which focus on safety measures.
5. Uterine cancer has a high cure rate if detected and treated in the early stages. Education and access to screening tests for uterine cancer along with early treatment would markedly reduce this rate.
6. Neonatal mortality rates, the infants from birth to one month of age, is a good measure of the care received by the mother prenatally and during labor and delivery.

Programs on normal growth and development or public health nursing consultation with parents about prenatal and infant care has helped reduce infant death rates.

Health Resources

1. The greatest need for public health services are in those counties with the fewest numbers of health care professionals, hospitals or nursing homes.
2. There are several counties without the services of public health nurses and sanitarians and very few counties with an adequate ratio of either.
3. The taxable valuation per capita effects local community ability to pay. However, the eastern part of the State has a higher taxable

valuation generally than the western part and yet there are more health services available in the western part.

4. In counties where the ranking of median family income is substantially lower than the ranking of per capita income, this indicates a relatively few individuals who are very wealthy and that the average family is poor (Madison County).

Social and Political

There is need to evaluate the health status indicators and health resources for each of the proposed multi-county districts and administrative regions as approved for State government use in determining geographic boundaries of health districts or regions and the location of central offices for delivering public health services.

Summary Findings -- Step 3

1. No model structural arrangement exists in other states that seems appropriate for Montana.
2. An incremental approach to changing the level of health services provided throughout the State is recommended.
3. There must be opportunity to select optional systems of administration and service delivery.

Appendix A

HOUSE JOINT RESOLUTION NO. 18

INTRODUCED BY TOWE, HUENNEKENS, NORMAN

A JOINT RESOLUTION OF THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA REQUESTING THE LEGISLATIVE COUNCIL TO CONDUCT A STUDY TO DETERMINE AN ACCEPTABLE MINIMUM LEVEL OF SERVICES TO BE PROVIDED BY COUNTY AND CITY-COUNTY HEALTH DEPARTMENTS, THE FEASIBILITY OF CREATING DISTRICT PUBLIC HEALTH DEPARTMENTS, AND AN ECONOMICAL MEANS FOR PROVIDING PUBLIC HEALTH SERVICES TO THE PEOPLE OF MONTANA.

WHEREAS, the people of Montana can benefit from equal access to public health services, and

WHEREAS, there is considerable difference in the kind, extent and level of service provided to Montanans, and

WHEREAS, the financial capabilities of the several counties for providing health services differ, and

WHEREAS, the natural boundaries for equitable delivery of public health services do not innately correspond to county and city.

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA:

That the legislative council be requested to ~~establish~~

CONDUCT A STUDY TO DETERMINE THE minimum levels of service for county and city-county health departments; and

BE IT FURTHER RESOLVED, that the legislative council and the Montana department of health and environmental sciences are requested to CONDUCT A STUDY TO determine the feasibility of creating district public health departments and requested to recommend the most economical means for accomplishing this task.

-End-

STUDY DESIGN FOR HOUSE JOINT RESOLUTION 18

DEFINITION OF THE PRESENT

Step No. 1 - Public health services provided in the State must be delineated. In addition, a description of the organizational structure and process within which these health services are provided must also be defined.

Health services must be described from at least three levels:

1. State
2. The local organized health departments
3. Unorganized local health departments, i.e., one nurse, one sanitarian, etc.

This information will be collected from two sources:

1. Collected data of the HJR-18 committee members
2. In-person interviewing using a standardized response format of public health stations scattered throughout the state by a committee of 8 to 10 consumers with direction provided by members of the HJR-18 Committee. All expenses incurred as a result of this investigation would be provided by the State Department of Health and Environmental Sciences.

This step would take place concurrently with Steps No. 2 and 3. The information derived from Step is meaningless until the information from Step No. 1 is obtained. The time frame for this endeavor would probably be approximately three months.

INDICATION OF NEEDS

Step No. 2 - "The Descriptive Approach"

A. Isolate 20 or more indices of population characteristics, health status and health resource status and provide this statistical information beforehand to:

   1. All committee members
   2. A group of five local public health personnel, made up of two M.D.'s, two nurses and one santiarian from both organized and unorganized local health departments.

   An analysis of Montana is then accomplished through a suggestion process coming from the committee members, and led by a person skilled in the descriptive analysis approach developed by James Kent, Denver. A map is used as a visual aid.

B. Following the statistical and geographic analysis of Montana, idealistic solutions would be suggested in response to problems and population characteristics which the committee had identified.

After this takes place the findings in Step No. 1 are related to the findings in Step No. 2; areas which now appear to be feasible but are not being fulfilled become part of a needs list.

Step No. 3 could be taking place concurrently with Step No. 1 or Step No. 2 a small study group would conduct a comparative analysis of multi-jurisdictional health service mechanisms operating in the country at the present time. There is one in Idaho, Utah, South Dakota, North Dakota; a small limited project in Eastern Montana and one in Cincinnati, Georgia, and in several other places in the country. These should be analyzed and the good and the bad points should be identified. The results of this comparative study should be presented to the committee. This study should also take approximately three months. At the end of the three-month period, Steps No. 1, 2, and 3 could be concluded.

Step No. 4 would be the synthesis of all the above information and alternative proposals would be created. Related recommendations would be listed. Alternative proposals could represent the multi-county, or multi-jurisdictional health provider organizations. Through this study we could also determine those things that could be changed in the State Health Department, local health departments and subsequently for local unorganized areas.

Step No. 5 would be the specific legislative proposal to be submitted to the Legislature in 1975.

TESTIMONY FOR JUNE 5, 1973

Mr. Chairman, members of the combined public health committees -- INTRODUCTION: I am Mary D. Munger, Nursing Consultant with the State Department of Health, serving today as a moderator for the testimony to be presented about H.J.R. 18. Following my preliminary remarks, other staff members from the Department have information to share with you.

We are here today primarily to report about efforts directed toward fulfilling the requests outlined in the resolution and to get your reaction to the work done to date, so we hope you will interrupt any of us to ask questions about our specific presentations or other questions you may have about the subject matter.

A steering committee of staff members of the State Department, representing the major divisions of the Department, has been authorized by Dr. John Anderson, the executive officer, to study the implications of the resolution and assume responsibility for collecting and synthesizing data in support of any legislative recommendations regarding minimum levels of service for county and city-county health departments.

A threshold question facing the steering committee was a definition of services to be provided through organized health departments. We have tentatively agreed to confine the study to traditional health services or those health services financed through a public source which, stated very simply, focus on control of communicable disease and the promotion of health habits which keep people well. Other words used to distinguish public health services from illness directed services are programs of prevention and maintenance.

There is further agreement by the steering committee that the basic components of traditional public health services are nursing, sanitation and health education combined with medical direction and service; that these are most effective within a single agency, located as close to consumers as possible; supplemented by adequate clerical services, and operating under policies established by a board of health representative of local goverments, local citizens and local health care providers.

To date, we have been trying to determine the availability of traditional public health services to people in Montana, the organizational arrangements through which services are available, and any changes that may be needed either at the state level or at local levels to more equitably distribute such service.

As stated in the annual report, "It is the basic function of the State Department of Health and Environmental Sciences to provide beneficial public health programs for the people of the state of Montana as required by state law and in accordance with regulations adopted by the State Board of Health and Environmental Sciences. It is the responsibility of the agency to assess health needs in the state, develop and maintain statistics on health problems and conduct health programs necessary for the protection and relief of the citizens of the state."

Individuals representing the basic components listed, medicine, nursing, sanitation and health education are employed in the State Department and travel to local areas to work with locally employed counterparts.

In addition to the basic components provided at the State level are several units of the State Department responsible for implementing laws regarding environment, such as air and water standards, occupational health and safety, and licensure of health care facilities.

Divisions and bureaus of the Department more involved in providing a direct service to local communities include the Division of Health Services, the Comprehensive Health Planning Division, the coordinated Laboratory Division, which combines a Microbiology Laboratory Bureau and a Chemistry Laboratory Bureau, and the Bureau of Records and Statistics.

It is becoming increasingly evident there are few people in the State who know about all the services available through the State Department or how to avail themselves of such service. Defining what services should continue to be provided at the State level as local services are substantially increased and the expense of providing direct public health services to local communities by people based in Helena are questions incorporated into the study.

Turning then to local health services. If a city-county board of health exists and employs a full-time health officer, sanitation and public health nursing services, the health department is classified as full time. To date there are four health departments which meet the above classification but there is a great difference in the range of services offered. Missoula City-County Health Department employs a full-time health officer, nine public health nurses, three sanitarians, and maintains a lab. Contrast this staff to the Silver Bow County Health Department with a full-time health officer, one sanitarian and one public health nurse. Lewis and Clark and Cascade Counties make up the full-time health departments.

Gallatin County with a physician health officer who works half time, two sanitarians and five public health nurses, almost qualifies as full time and provides a wide scope of services. The remaining 51 counties vary greatly in the amount of services available and in most of them a physician with a full-time private practice serves also as a health officer and depends on nurses and sanitarians to implement local programs.

Another interesting slide shows the amount of State Department monies available for local areas. Financial arrangements are made between the Department and usually the county commissioners.

To enlarge on the preliminary statements I've made, we have other Department staff members:

Dr. Steve Kairys will describe the activities of the Health Services Division of the State Department.

Vern Sloulin will describe the scope of services available through the Environmental Services Division.

Virginia Kenyon will talk about existing public health nursing services in the State.

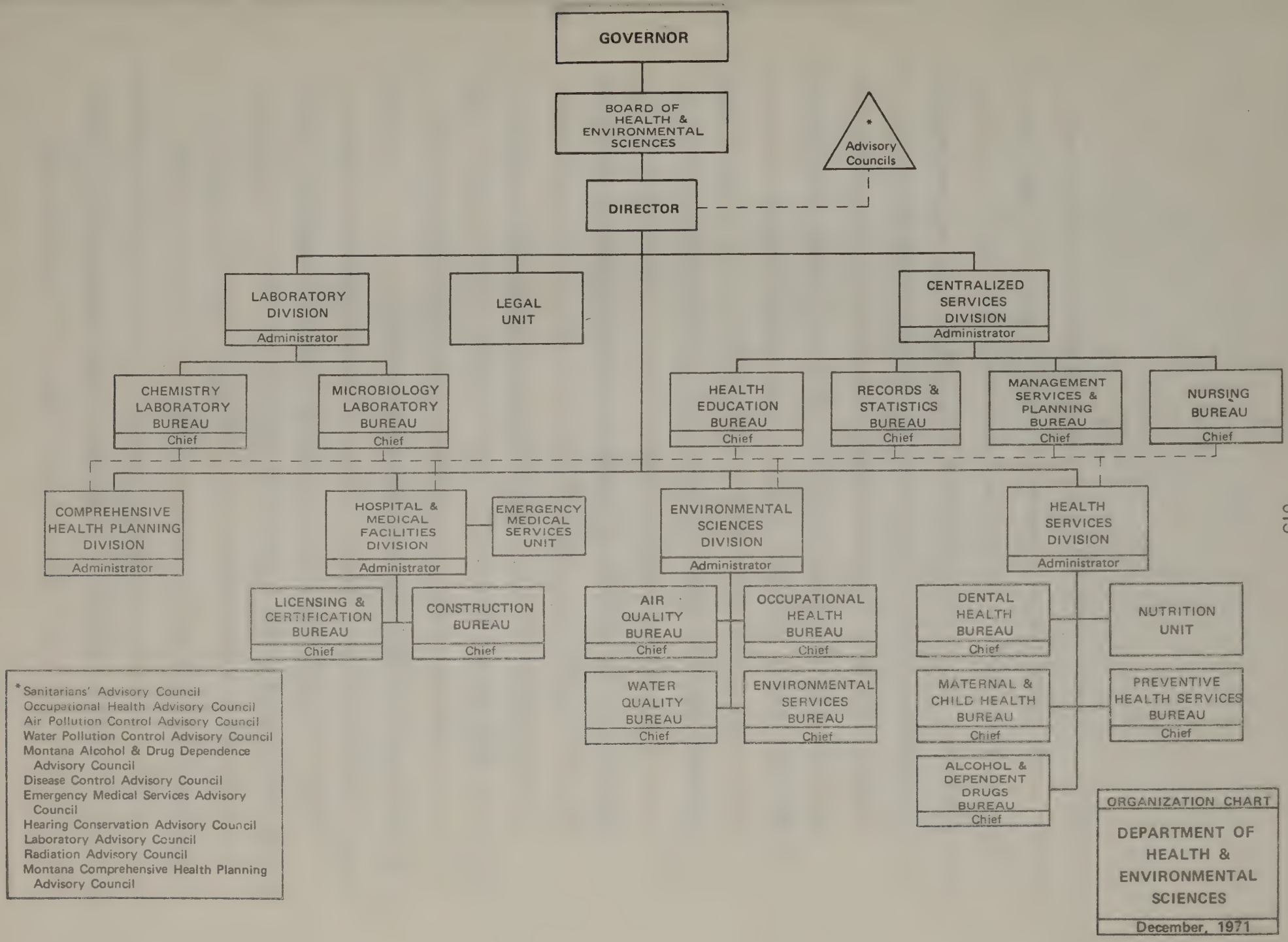
Bob Loughrie will talk about the work of the Health Education Bureau.

Mike Harrington will describe the services of the Laboratory Division.

Robert Johnson will tell you about the Division he administers, Comprehensive Health Planning, and will also describe the design of the study outline we hope to follow in completing the study as requested in HJR 18.

State Department of Health and Environmental Sciences
1972 Annual Report
Principal Goals

It is the basic function of the State Department of Health and Environmental Science to provide beneficial public health programs for the people of the state of Montana as required by state law and in accordance with regulations adopted by the State Board of Health and Environmental Sciences. It is the responsibility of the agency to assess health needs in the state, develop and maintain statistics on health problems, and conduct health programs necessary for the protection and relief of the citizens of the state. Principal objectives of the Department are to: 1) administer and supervise activities involved in the preparation of the comprehensive state health plan and to modify on-going health programs or initiate new programs to reflect recommendations of the state plan; 2) evaluate health programs and select those most needed and beneficial for state residents in order to provide the highest possible quality of health services within the limitations of available resources; 3) meet the needs of populations at risk and design health programs to improve their health and protect the general population; 4) enforce state health laws and defend actions brought against the Board or Department; 5) adopt and enforce rules and standards for carrying out legal responsibilities and for the preservation of the public health and the prevention of disease; 6) supervise activities of local boards of health and provide assistance so that public health services will eventually be made available to all citizens in all areas of the state.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DENTAL HEALTH BUREAU
Chief
NUTRITION UNIT
MATERNAL & CHILD HEALTH BUREAU
Chief
PREVENTIVE HEALTH SERVICES BUREAU
Chief
ALCOHOL & DEPENDENT DRUGS BUREAU
Chief
*Sanitarians' Advisory Council
Occupational Health Advisory Council
Air Pollution Control Advisory Council
Water Pollution Control Advisory Council
Montana Alcohol & Drug Dependence Advisory Council
Disease Control Advisory Council
Emergency Medical Services Advisory Council
Hearing Conservation Advisory Council
Laboratory Advisory Council
Radiation Advisory Council
Montana Comprehensive Health Planning Advisory Council
ORGANIZATION CHART
DEPARTMENT OF HEALTH & ENVIRONMENTAL SCIENCES
December, 1971

C10

PROGRAM: HEALTH SERVICES DIVISION

GOAL

To protect and improve the health of the people of Montana by preventing and/or controlling chronic illness and communicable diseases, supporting maternal and child health programs, providing epidemiological, family planning, health education, dental health and nutrition programs; and coordinating alcohol and drug programs. The Health Services Division includes the Bureaus of Dental Health, Maternal and Child Health, Preventive Health Services, Alcohol and Dependent Drugs, and the Nutrition Unit.

OBJECTIVES

1. To make family planning services available to all women of child bearing age.

2. To reduce infant mortality rate from 21.7 per 1,000 live births to a rate of 15.0 per 1,000 live births within the next five years; to reduce the mortality rate among preschool children by a similar ratio.

3. To assure treatment and provide epidemiological services, including gonorrhea culture screening programs, for all venereal disease cases.

4. To organize an effective health care system for migrant workers in Montana.

5. To provide screening clinics for adults for early detection of chronic diseases.

6. To provide comprehensive health screening services for children who otherwise may not have access to such services.

7. To help families of handicapped children provide needed care to give the children the best possible chance to function at the highest level.

8. To increase public awareness concerning the prevention and alleviation of hearing problems, the causes, results and various ramifications of hearing loss.

9. To assist parents in meeting the needs of their children who are born with or develop impaired hearing.

10. To reduce the impact that alcoholism and drug abuse have upon the personal and public health, welfare, mental, social and economic well being.

11. To reduce and control dental disease in the general population through programs of prevention, services, education and research.

12. To maintain surveillance on all reportable infectious diseases in Montana and to provide epidemiologic services when indicated.

13. To control chronic illness by programs of early diagnosis, follow-up therapy, adequate nutrition, rehabilitation and education.

14. To continue present community case-finding programs in tuberculosis with more emphasis being placed on high risk groups.

HEALTH SERVICES DIVISION (continued)

OBJECTIVES (continued)

15. To provide a wide range of services and programs focusing upon the whole man and provide multiple approaches for the resolution of the multi-faceted problem of alcohol and drug abuse.

16. To participate with other state agencies in Youth Development and Delinquency Prevention Rural America Project.

ACCOMPLISHMENTS

1. Grants of approximately $400,000 enabled Family Planning Programs in Butte, Billings, Missoula, Hamilton, and Miles City to be expanded, and new programs to be implemented in Bozeman, Glasgow, Glendive, Helena, and Kalispell.

2. Adult screening programs resulted in 1,180 persons being evaluated in coronary heart disease prevention clinics; 8,174 persons were screened for diabetes; 330 people were screened for glaucoma and 228 persons attended pilot multiphasic screening clinics.

3. The gonorrhea control program utilized five field representatives in the follow-up program, interviewing approximately 300 diagnosed male patients. Approximately 5,000 females were involved in a gonorrhea screening program through private physicians' offices and family planning clinics.

4. A total of 607 individuals were served by the Migrant Health Project staff. Hospitalization and dental care were 1972 additions to the clinical services offered by eight participating physicians.

5. Execution of an agreement between the State Department of Health and Environmental Sciences and the State Social and Rehabilitation Services will provide for establishing and maintaining early periodic screening programs for Title XIX children.

6. Twenty-one thousand children and 2,857 pregnant women were provided with a wide variety of services including the surgical correction of congenital anomalies, health maintenance, hearing conservation, dental health, diagnosis and evaluation of the mentally retarded, information and referral for health problems, public health nursing, nutrition, primary prevention, school health and safety education, and the provision of drugs and biologicals.

7. Six hundred twenty-seven children received physicians' services under the Crippled Children's Program; 193 were new cases.

8. Seven hundred three mothers and 337 fathers attended 39 series on Education for Parenthood.

9. Public health nurses made 5,318 visits to 2,461 maternity patients both before and after delivery to provide information and health promotion services to mothers and their infants.

June 5, 1973

TESTIMONY FOR INTERIM PUBLIC HEALTH COMMITTEE
(Legislative)

Nurses make up the largest number of public health workers providing services to people. While they are nurses primarily, and must utilize their nursing knowhow, they must also use the concepts of public health which have been somewhat different from hospital nursing. Public Health Nursing focuses on families where they live or work or go to school. The community is the patient of public health workers. Prevention of illness, maintenance of health, and early case finding are their main functions.

The public health part of the nurses' knowledge is best learned in a school of nursing, but many of the nurses in Montana have not had public health in their backgrounds. Nurses are employed by local boards often because they are available. Many of these employing nurses have little understanding of the work to be done by public health nurses. They have little understanding of the community aspects or the planning of health programs to help people to stay well rather than to get well. They do see vision testing and immunizations as preventive practices, but that's about as far as most of their understanding goes. By the time nursing consultants have met with them several times it is time for electing a new group and we start all over.

Most writers of Public Health Administration are still advocating one public health nurse to every 5,000 people. Montana comes nowhere near meeting that ratio, and because of the large areas to be served, one nurse to 5,000 is not adequate. One nurse is trying to provide services in two counties, Garfield and McCone. There are not many people in these counties. It is in Garfield County that we have only .4 of a person per square mile.

There are 125 nurses in public health positions and there are 13 counties with no nursing service.

Never at any time have we had an adequate number of nurses working in public health in Montana, and only one-half of those working locally have had preparation for their public health jobs. We are preparing enough nurses in Montana, but not many of these wish to work in remote spots such as Scobey or Alzada, so we have a problem with distribution.

The largest number of prepared nurses are in Bozeman and Missoula. The largest staffs are in Great Falls, Billings, and Butte. In all three towns the school districts provide most of the financial support. Since they provide funding, they demand service, so the people in these communities get very little nursing service. Most of the time is spent in the schools, and the school age is the healthiest age, so we have inequities in the funding system.

Indians on reservations fare better from a standpoint of available services, because the Indian Health Service provides many services not available to all Montana citizens, including Indians who live off the reservation.

The Nursing Bureau of the State Department of Health is charged with supervision of nurses employed in public health positions, including school nursing. We have four generalized consultants to cover all of the state, plus one each in MCH, family planning, tuberculosis, and one half-time nursing educator who assists with all inservice education and provides consultation to all department programs involving nursing.

We work closely with MSU in providing field placement in public health. The number of students has doubled in the past few years. There are 160 students to be placed next fall and winter, in addition to R.N.'s going back to Bozeman to get their degrees. We have only one baccalaureate program in Montana.

VK:bd

Statement regarding minimum public health services in Montana.

FOUNDATION FOR PUBLIC HEALTH SERVICES

Citizens are served best when the basic components of public health services, nursing, sanitation and health education, are combined within a single agency, are coordinated by a qualified health officer, are supplemented by adequate clerical services, and operate under policies established by a board of health representative of local governments, citizens, and health care providers.

All activities of any health department should be directed toward meeting public health needs identified statistically, by consumers, and by public health personnel.

Public health services, those which stress prevention of illness and maintenance of a satisfactory level of wellness, should be integrated with restorative and rehabilitative services. Planning for such comprehensive health services should be a continual process between consumers, health care agencies and individuals providing the service.

Because public health services should be available to all persons, public funds should be used to underwrite basic costs. However, public agencies can establish fees for certain services if the costs are not a barrier to people receiving the service they need.

The use of indigenous outreach workers is encouraged to help people know about public health services and how to avail themselves of such service. Bringing health service to people who live many miles from a main health department is an essential part of planning.

THE NURSING COMPONENT

Nursing plays a key role in any plan designed to provide public health services to Montana citizens whether such service is offered within the boundaries of one county or through a multi-county organization. Nurses employed in organized health departments prefer to be called community health nurses instead of the more familiar caption public health nurse. The change in title also connotes a change in the scope of services provided by nurses who have special educational preparation to function in community settings. Their interest extends to all factors within a given community which affects the health status of individuals.

While some of Montana's larger cities may need community health nurses with specialized skills such as maternal and child health specialists or mental health nursing specialists, the majority of Montana communities can be adequately served by a generalized nursing program.

Where two or more nurses are employed in one agency their work should be coordinated and evaluated by a nursing supervisor. Nursing consultants employed by the state public health agency provide a direct liason with local nursing services and facilitate joint planning and implementation of nursing programs.

As a member of a health team in a community participating with citizens and other health professionals in planning for ways to meet health needs nurses will use a variety of methods and approaches. However there are some nursing activities of a general nature which can be implemented in most communities.

The nurse is concerned primarily with preventing illness and disability, identifying health problems, assisting families in obtaining care and treatment, and promoting rehabilitation.

Much of the work of community health nurses is done in the home or in small groups helping families understand a health problem and finding ways and means of coping with the problem; or in small groups such as education for parenthood classes.

The nurse is often a person's first contact in a given episode of illness and helps the individual or family decide what must be done to help resolve the problem as well as assuming the responsibility for maintaining contact with that patient through a regime of diagnosis, treatment and rehabilitation.

Many people served by the nurse will not be sick but may need preventive supervision during periods of stress. Vulnerable groups, for instance children in broken homes or suffering from physical or emotional deprivation may require special protection. Anticipatory guidance such as preparing a geriatric patient for problems associated with the aging process of readying the family of a hospitalized psychiatric patient for his return takes an important place in nurse's plan of work. Helping parents understand normal growth and development processes including emotional changes as well as discussing concepts and methods of family planning fit into the nursing role.

EXAMPLES OF COMMUNITY HEALTH NURSING FUNCTIONS:

Give direct nursing care in a person's home or teaches other family members to give such care.

Observes a patients reaction to medications and advises the patients,consults with the patients physician.

Consults with a private physician about altering a patient's medication following home visits to observe and measure vital signs.

Arranges clinics for nurse or physician assessment of physical and social growth and development of infants and preschoolers.

Arranges for public sponsored immunization clinics.

Conducts group discussion type classes for overweight people, parents of adolescents, senior citizens, etc.

Consults with school personnel about detecting children with physical or emotional health problems or developing a health curriculum with the school.

To provide generalized community nursing described above requires the skill and knowledge of a qualified community health nurse. Minimum qualifications for a beginning community health service: a current license as a registered nurse in Montana and a baccalaureate degree from an accredited university. A recommended ratio for a public health nursing service which stresses prevention and mainteance is one nurse per 4,000 population. If the nurse is also available to give direct care to ill or convalescing people in their homes, the recommended ratio is one nurse for every 2,500 population.

Adjusting the ratio for sparsely populated areas of Montana would result in a more realistic average proportion of one nurse for every 3,000 persons, or approximately 234 community health nurses for the entire state.

Prepared by: Mary D. Munger

5/22/73

CURRENT POFILE OF COMMUNITY HEALTH NURSING SERVICES

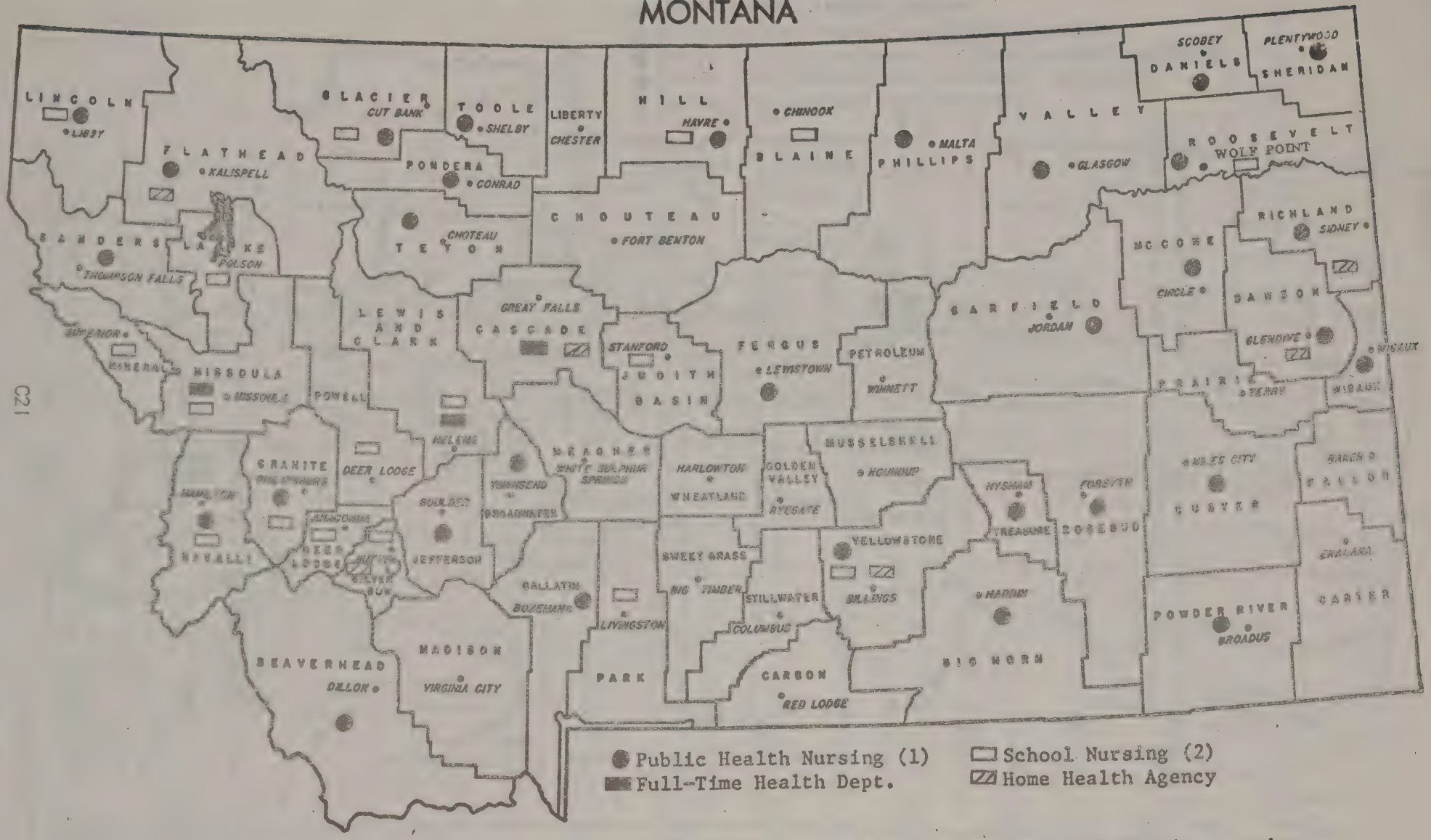
May 1973

Total number employed in some type of community service in local Montana communities	124
Nurses employed in the three full time health departments	35
Nurses employed in counties with two to four nurses	18
Nurses employed in single county situations	
(full time	23
part time)	6
Nurses employed by school districts including Head Start projects	
(full time	35
part time	7
Total	124
Counties without any nursing services	13
Counties served only by part time school nurses and no other community nursing service	7

This profile does not include nurses employed by the state department of health for consultation or special projects, such as tuberculosis control, MCH, or family planning.

Nurses who provide home health services through a health department are included in this profile but nurses employed by the two hospitals and another independent agency to provide home health services are not included.

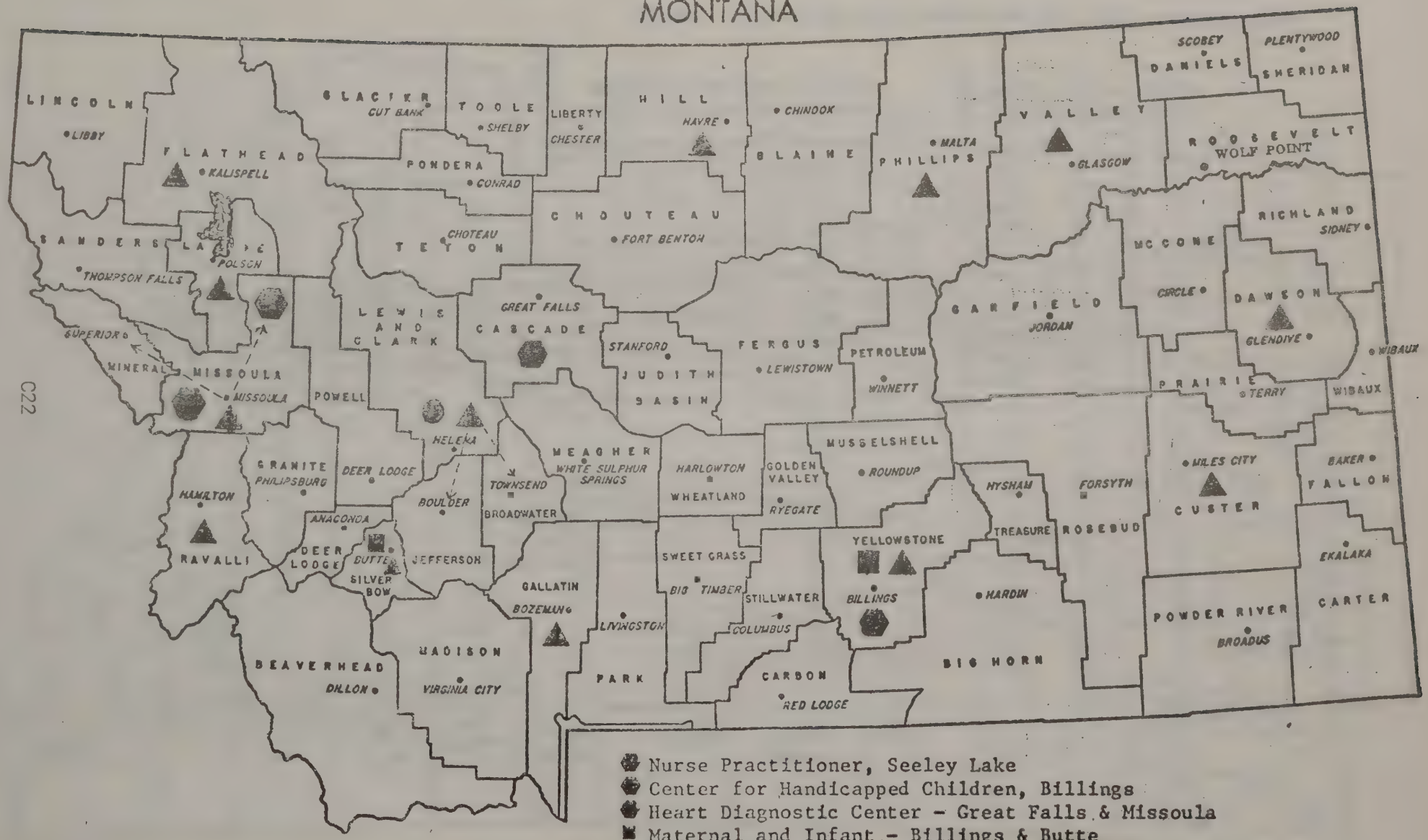
Map of Nursing Service Available in Montana



(1) and (2) include both full-time and part-time services.

Nursing - Special Services & Projects

MONTANA



- Nurse Practitioner, Seeley Lake
- Center for Handicapped Children, Billings
- Heart Diagnostic Center - Great Falls & Missoula
- Maternal and Infant - Billings & Butte
- Children and Youth, Helena
- Family Planning Clinics

TESTIMONY AT PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE

June 5, 1973

Laboratory Division, Michael J. Harrington

The Laboratory Division serves as:

1. A reference laboratory for difficult and unusual procedures and those that would be inordinately expensive if not done in a large volume.

2. Providing services and special studies that are required by Board regulation and by law.

3. Direct support of departmental programs.

It does this through the Chemistry and Microbiology Laboratory Bureaus:

1. Chemistry Bureau provides environmental monitoring through air and water quality control programs.

   a. Air quality tests for hydrocarbons, fluorides, lead, host of other particulates.

   b. Water quality, tests for solids, detergents, pesticides and a battery of assorted minerals and quality indicators.

   c. Highway Alcohol Program is a contract service of the Chemistry Laboratory. Samples of blood, breath and urine are analyzed for alcohol content. Blood and urine analyzed for dangerous substances, upon request.

2. Microbiology Laboratory has various programs to support in the early diagnosis, control and prevention of disease.

   a. Virology - such as rubella, Rocky Mountain Spotted Fever.

   b. Mycobacteriology (Tb.).

   c. Mycology (fungi & yeast).

   d. Parasitology.

   e. Venereal disease serology.

   f. Bacterial analysis.

   g. Throat cultures for streptococci, rheumatic heart disease prevention.

   h. Extensive determinitive bacteriology.

Along with providing services, the Laboratory strives to:

1. Improve the performance of hospital and private laboratories around the State through proficiency testing with:

a. 60 laboratories participating in V.D. serology testing.

b. 75 in bacteriological testing.

Note: To be assured of accurate results of laboratories, the personnel of these laboratories should be qualified and this should be mandatory. Enforced through legislation if possible.

2. Improve the quality of its own services through external quality control programs.

Summary: The purpose of the Department of Health and Environmental Sciences Laboratory is to provide competent and economical assistance to physicians and public health personnel and through them the citizen of Montana in the control, prevention and early diagnosis of disease and in the protection and maintenance of the environment.

MONTANA DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
ENVIRONMENTAL SCIENCES DIVISION
ENVIRONMENTAL SERVICES BUREAU

REPORT OF ENVIRONMENTAL SERVICES PROVIDED IN MONTANA

BY THE DEPARTMENT OF HEALTH & ENVIRONMENTAL SCIENCES

Report Presented by Vernon E. Sloulin, Chief,
Environmental Services Bureau
To Combined Public Health Committees

Programs of environmental control are primarily administered through the Environmental Sciences Division of the department; however there is some environmental control provided through other divisions, such as those that relate to hospitals and medical facilities. This phase of environmental control is provided through the Hospital and Medical Facilities Division.

The Environmental Sciences Division has multiple program objectives of health, safety, comfort, and well-being in arriving at its overall goal of protecting man in his environment. All programs are consumer protection oriented. Services are provided via education, inspection, consultation, and enforcement.

The Environmental Sciences Division is divided into four bureaus. They are: Air Quality Bureau, Occupational Health Bureau, Water Quality Bureau, and Environmental Services Bureau. The division has two branch offices -- one located in Kalispell and the other in Billings. Services from branch offices are confined primarily in the areas of air and water pollution control.

The basic programs of the division include:

1. Air Pollution Control

This involves control of industries and private sources of air

pollution, and cover such things as chemical, dust and smoke.

2. Water Pollution Control

This program involves control of potential pollution from industries, municipalities, and private sources. It covers chemical, biological, and thermo pollution.

3. Control of Public and Private Water Supplies

This program consists of surveillance of public water supplies and supplies which serve public establishments. Involves inspection and laboratory analyses for bacterial and chemical content.

4. Solid Waste Disposal Program

This is a program to control collection, storage and disposal of all solid wastes including municipal and private sources. It also involves a vehicle disposal program, which involves recycling old automobiles.

5. Food & Drug Control

Montana has the model, uniform food and drug law in effect. This program involves control of foods, drugs, and cosmetics, primarily for misbranding and adulteration, which involves inspection of establishments handling these products plus actual surveillance of the products on retail level.

6. Public Accommodations Licensing & Control

This program involves licensing and inspection of all cafes, bars, hotels, motels, retirement homes, trailer courts, and campgrounds. It also includes inspection and surveillance of schools and jails; however, these latter establishments are not licensed.

7. Pesticides

This program confined to investigation and study of pesticides only as they affect human health and the environment.

8. Vector Control

This is one which provides assistance to local areas

regarding control of insects and rodents which affect public health, these being primarily mosquitoes and rats.

9. Subdivision Control

Subdivisions now include housing developments as well as trailer courts, the latter which we have been inspecting and licensing for years. This involves all aspects of subdivisions which might affect public health, especially water and sewage systems as well as solid waste disposal.

10. Public Swimming Pool Control

Public swimming pools include municipal pools as well as pools which are constructed as part of a public establishment such as a motel. Program involves one of plan review and inspection to insure that these pools are constructed and maintained whereas they will be safe for public use.

State Environmental Programs in Relation to Local Public Health Programs

All state environmental control programs are dependent upon local health department support and activities in order to be completely effective. Local sanitarians are the individuals who extend state programs to the field level. By law they are legal representatives of the state. All licenses handled by the division are distributed through local health departments and the local sanitarians.

There are 11 counties which still do not have sanitarian services; therefore, the extent of state environmental control programs to these areas is extremely limited in that there is no local personnel through which to develop and implement environmental control programs. Attached is a map which indicates the areas and locations having sanitarian services. Also attached is an information flyer indicating the types of services provided by sanitarians.

Local sanitarians are employed under several different types of arrangements. They are either employed by cities, combinations of city-county, or combinations of counties. The department assists local health departments financially to employ public health personnel, including sanitarians.

In fiscal 1973, $85,322 was provided with as little as $670 going to Treasure County, and the high of $22,060 to Cascade County. Monies are also provided through the Air Pollution Program, and in fiscal 1973 approximately $6,500 was distributed to assist local departments in air pollution programs. The air pollution program also provides funds to non-public health people to assist with air pollution programs. There are two such individuals in the state.

As new state programs are added by passage of new legislation very little and sometimes no extra funds are added to provide financial assistance to local health departments to assist in implementing broader programs of environmental control. Yet they are expected to assist, and the public in most cases demands expansion of local programs as they relate to new state legislation adopted.

Local government units are faced with problems of liability if they do not provide services such as routine surveillance of public eating establishments. The City of Billings was threatened with a liability suit a few years ago due to an outbreak of food poisoning in one of the local cafes; however, it was found that they were providing reasonable surveillance of the food establishment involved, so the City was not included as one of the defendants in the case. Several cases were filed against the establishment, and they were successful on the part of the plaintiffs.

Future Needs

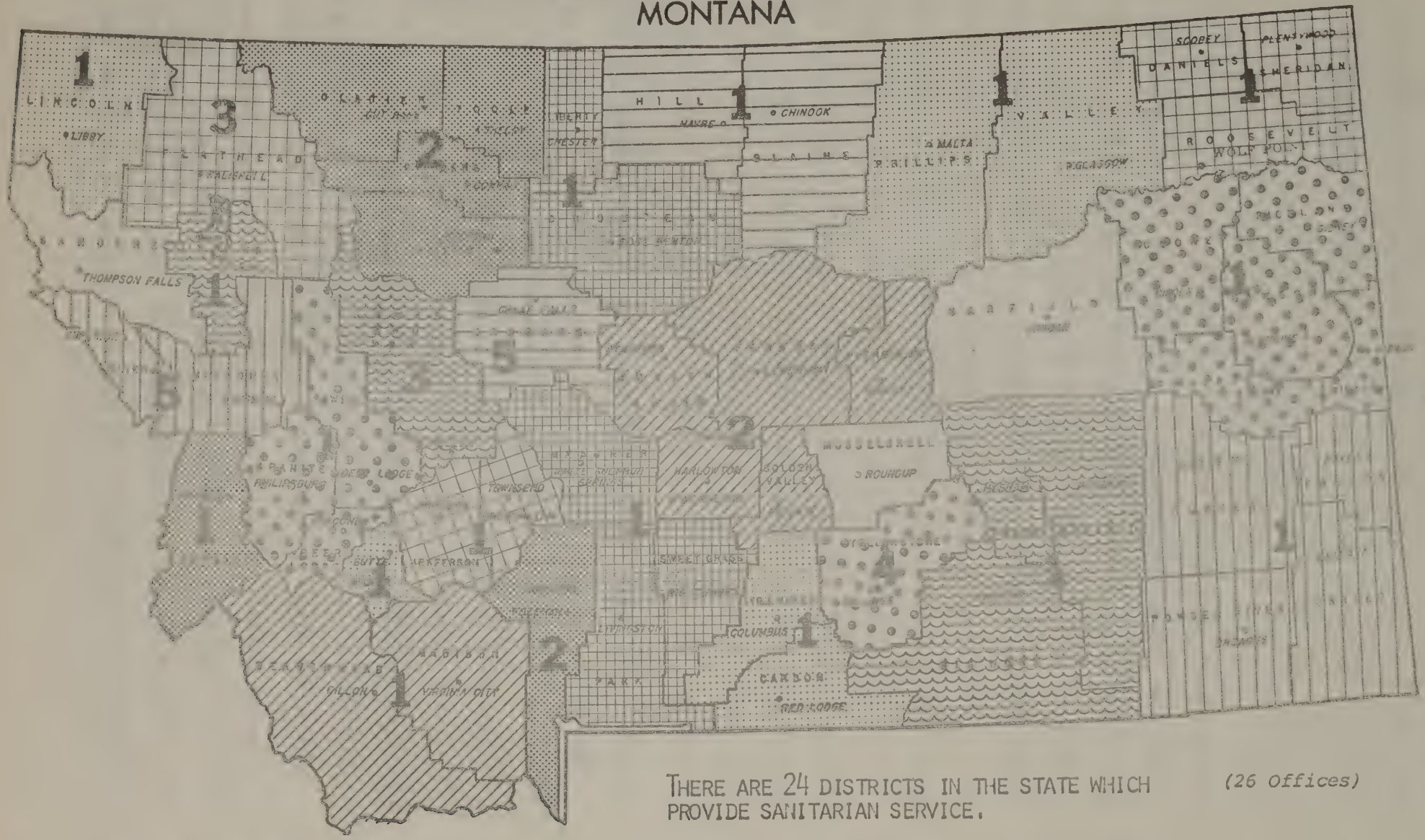
One of the prime goals of the division has been to increase and improve local sanitarian coverage of Montana so that the entire state would

have some degree of environmental control on the state and local level. This program of improved local sanitarian service has been in effect since 1953. It has been quite successful; however there are still 11 counties without sanitarian services and many of these 11 cannot afford to finance this type of service without a great deal of state aid or some other arrangement to provide service, such as creating multi-county districts.

Division staff are quite enthusiastic about House Joint Resolution No. 18, in that it does direct Legislature to study the possibility of districting to provide public health services. It is our opinion that the only way we can provide reasonable public health services to the entire state of Montana is through some type of districting plan which provides for financial participation by all areas involved plus state level financial assistance.

SANITARIAN SERVICE 1973

MONTANA



THERE ARE 24 DISTRICTS IN THE STATE WHICH PROVIDE SANITARIAN SERVICE. *(26 Offices)*

42 SANITARIANS AT LOCAL HEALTH DEPARTMENTS.

(2 more at Billings, County Air Pollution Control)

No. 1052 — County Outline Map
STATE PUBLISHING COMPANY
Helena

SANITARIAN DISTRICTS

Districts	Population	Population per Sanitarian
A (Lincoln County)	18,063	18,063
B (Flathead County)	39,460	19,730
C (Glacier, Teton, Pondera & Toole Counties)	29,349	29,349
D (Chouteau & Liberty Counties)	8,832	8,832
E (Hill & Blaine Counties)	24,085	24,085
F (Valley, Daniels, Sheridan & Roosevelt Counties)	30,698	30,698
G (Lake County)	14,445	7,222
H (Missoula & Mineral Counties)	61,221	20,407
I (Granite, Powell & Deer Lodge Counties)	25,049	25,049
J (Lewis & Clark County)	33,281	11,093
K (Cascade County)	81,804	16,360
L (Fergus & Judith Basin County)	15,278	7,639
M (McCone, Richland, Dawson, Prairie & Wibaux Counties)	27,198	27,198
N (Ravalli County)	14,409	14,409
O (Silver Bow County)	41,981	41,981
P (Gallatin County)	32,505	16,252
Q (Park, Meagher & Sweet Grass Counties)	16,299	16,299
R (Stillwater & Carbon Counties)	11,712	11,712
S (Yellowstone County)	87,367	21,841
T (Big Horn, Rosebud & Treasure Counties)	17,158	17,158
U (Custer, Fallon, Carter & Powder River Counties)	21,042	21,042

POPULATION SERVED BY SANITARIANS. 651,236

STATE POPULATION. 694,409

PERCENTAGE OF ENTIRE STATE POPULATION SERVED. . . . 93.8%
(651,236 - 694,409)

Health Education Bureau

The Health Education Bureau is a service bureau to other Divisions of the State Department of Health and Environmental Sciences and to all communities in Montana. Some of the more important services rendered by this bureau are as follows:

a. Provides assistance in promoting developing and implementing health education programs
b. Community organization
c. Educational aids
d. Information
e. Consultation
f. Direct education

These services are provided through at least three mechanisms. They are:

a. By cooperative planning with other bureaus and other state and community agencies
b. By in-house initiation
c. By request

Suggested Improvements

Consensus among the health education staff was that our health education services were not being utilized nor were they readily available to all communities in Montana. The rectifying suggestion for this was to implement regional health departments throughout the state, each to include a regional health educator.

As a precursor to these departments, it was suggested that five regional health teams (corresponding to the five CHP areas)

be implemented. The functions of these RHD's would be:

a. To provide a vehicle for the assessment, development, and coordination of all health services and programs

b. To coordinate activities with all related regional agencies

Staff personnel agreed that budgeting policy be studied and possibly changed so that the Health Education Bureau would have an independent budget in order to provide services to all divisions and bureaus. One way in which this could be facilitated would be to prorate the cost of the Centralized Services Division throughout the entire Department, the change being based on use of CSD personnel.

PROGRESS REPORT OF HJR 18

To

INTERIM PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE

October 15, 1973

Following the report made to the interim legislative committee in June, 1973, and the recommendations from the legislators to limit the study to the availability and provision of "traditional" services by public health department, and to concentrate on the feasibility of a district structure through which to provide public health services, the study committee has moved ahead.

The original committee of eight staff members of the Department of Health and Environmental Sciences has been enlarged to a total of 22 members. Ten of the committee members represent various Bureaus within the Health Department; two are local, full-time health officers; there is one public health nurse from a local area, and one outreach worker; there is one Senator, two state representatives; three consumers, and Beth Richter.

Two Bureaus of the State Health Department have borne the expense of the committee's work to date which have included paper, postage, secretarial services, and some mileage and per diem reimbursement for the three consumer-legislator teams. Local agencies have paid expenses of members who do not live in Helena to attend the meetings in Helena. Definite funding will be required when the final report is ready for distribution and discussion statewide prior to the 1975 legislature, especially if the report contains recommendations relative to changing the laws regarding public health services.

Since the June report to the interim committee, there have been three meetings of the full committee and several meetings of the sub-committees assigned to the first three parts of the study design. This report will focus briefly on the work of the three sub-committees assigned to the first three parts of the five-part study design.

The assignment to the sub-committee dealing with step one of the study design is to delineate public health services which are now being provided throughout the state either at the state or local levels. Personnel providing public health services such as health officers, sanitarians, and public health nurses, are being questioned about their work and are being asked to outline health services they believe should be made available to everyone at public expense.

Three teams composed of two people, a legislator and a consumer, are preparing to conduct interviews about health services in three geographic areas of the state. Each team will contact people in a county with many public health services provided in a coordinated manner, in a county where public health services are fragmented, and in a county where there are minimal health services. The teams are trying to find out if people know what services are available, whether or not they believe the services are readily available and effective, and what services they believe should be provided at public expense.

The two local health officers, the local public health nurse, the outreach worker, and the statistician from the State Department of Health comprise a sub-committee for step two of the study design. This committee is attempting to determine which population characteristics are most important as the basis for planning for public health services for both the content and the financing mechanisms. While statistics about causes of death, incidence of illness, birth rates, etc. may seem obvious indices for this purpose, such factors as location of health services, numbers and location of physicians and other types of health personnel, usual marketing centers of the state are also being considered.

Under step three of the study design, a sub-committee is collecting data from other states about existing structural arrangements through which they are providing

public health services. Responses to a questionnaire sent to several states is providing information about the variety of health services offered as well as about the types of organizational arrangements. This sub-committee is considering a follow-up contact of those states which have experience with district or regional health departments in an attempt to get opinions about the structural arragements, the financing, the qualify and effectiveness of the services.

A meeting of the full committee is planned for December 6 when it is hoped the group can analize the data collected, determine its adequacy, and, perhaps, begin to consider the implications for Montana.

ns
10/15/73

HJR 18 STUDY COMMITTEE

Step No. 1 - Consumer sub-committee

Standardized response format to be used by consumer teams during their in-person interviewing.

Three teams composed of two people each will use the standardized response format as a guide for their investigations in their respective areas. One member of each team will be a legislator and the other member will be a private citizen designated by Comprehensive Health Planning. At least three county areas are to be studied by each team--one county with many services in a somewhat coordinated system, one county with some fragmented services and one county with minimal or no services.

Members of the consumer teams are as follows:

1. Representative John Driscoll
   424 S. 2nd — Home Phone 363-2155
   Hamilton, MT 59840

   Mr. Hugh Standley
   617 Minnesota — Home Phone 543-5245
   East Missoula, MT 59801

2. Representative Dorothy Bradley
   Rte. #3 Box 114 — Home Phone 586-2823
   Bozeman, MT 59715

   Mrs. Margaret Raihl
   120 S. G Street — Home Phone 222-3684
   Livingston, MT 59047

3. Senator Gordon Bollinger
   217 Klein — Home Phone 228-2337
   Glasgow, MT 59230

   Mrs. Evelyn Dorr
   East Glasgow, MT 59230 — Home Phone 367-4205

In an effort to standardize the legislator/citizen consumer team's investigations the following guidelines and response format were agreed upon by the consumer sub-committee of the HJR 18 Study Committee at their September 6 meeting in Helena:

I. INDIVIDUALS TO CONTACT AND INTERVIEW

A. Consumers of public health services-special attention to be given to insuring variety in socio-economic background (income, ethnic background, sex etc.) and geography (rural, urban, etc.)

B. Public Health Officials
   1. sanitarians
   2. health officers/administrators
   3. public health nurses
   4. mental health personnel

C. Various informal health-decision makers
   1. social workers
   2. outreach workers
   3. social organizations
   4. voluntary health programs
   5. programs for the elderly

D. Locally elected or appointed officials
   1. county
   2. city
   3. school officials

E. Private health professionals
   1. doctors
   2. dentists
   3. local medical societies

II. SUGGESTED BASIC QUESTIONS TO BE ASKED BY ALL CONSUMER TEAMS

A. What public health services are you aware of that are being provided in this county?
   1. nursing?
   2. health education?
   3. sanitation?
   4. mental health?
   5. other preventative programs?

B. What public health services would you like to see provided in your area?

C. What experiences have you had in attempting to use the services provided by your local public health people?

D. How do you feel about the present administrative structure relating to public health services? Changes?

E. Do you have a local board of health?
   1. who is on it?
   2. what are their duties?
   3. changes?

F. How are public health service priorities set in your community? By whom?

G. Comment upon the attitude and competency of public health providers.

H. Are there salary and staffing problems with your present public health system? Changes?

I. How do you think public health services should be funded?

J. How involved would you like to become in the provision of public health services?
   1. how?
   2. why?

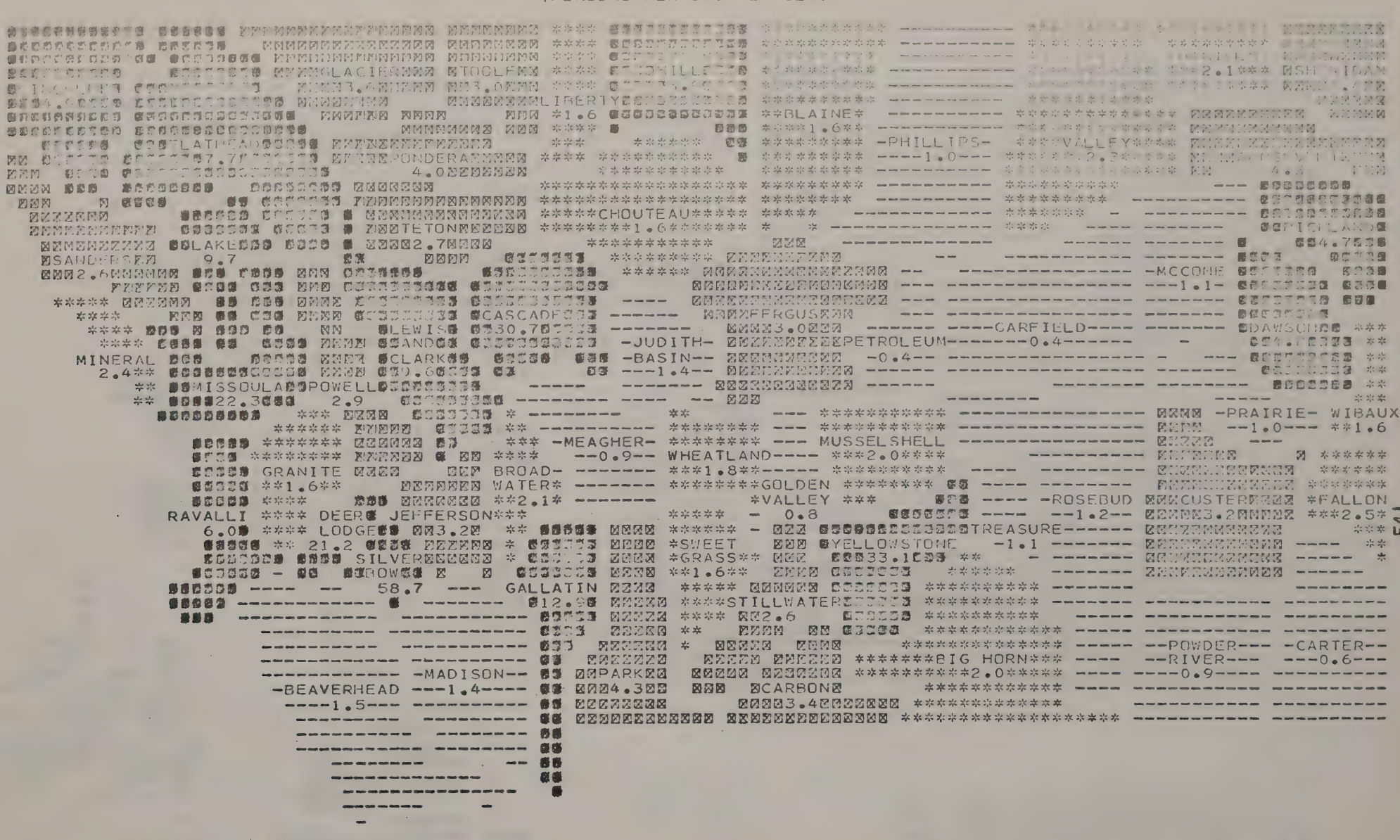
POPULATION - MONTANA COUNTIES, 1970

SOURCE: BUREAU OF THE CENSUS.

----	675. - 2862.	LOW QUARTILE
****	2875. - 6116.	MEDIUM LOW QUARTILE
****	6473. - 11471.	MEDIUM HIGH QUARTILE
****	12174. - 57367.	HIGH QUARTILE

POPULATION DENSITY - MONTANA COUNTIES, 1970

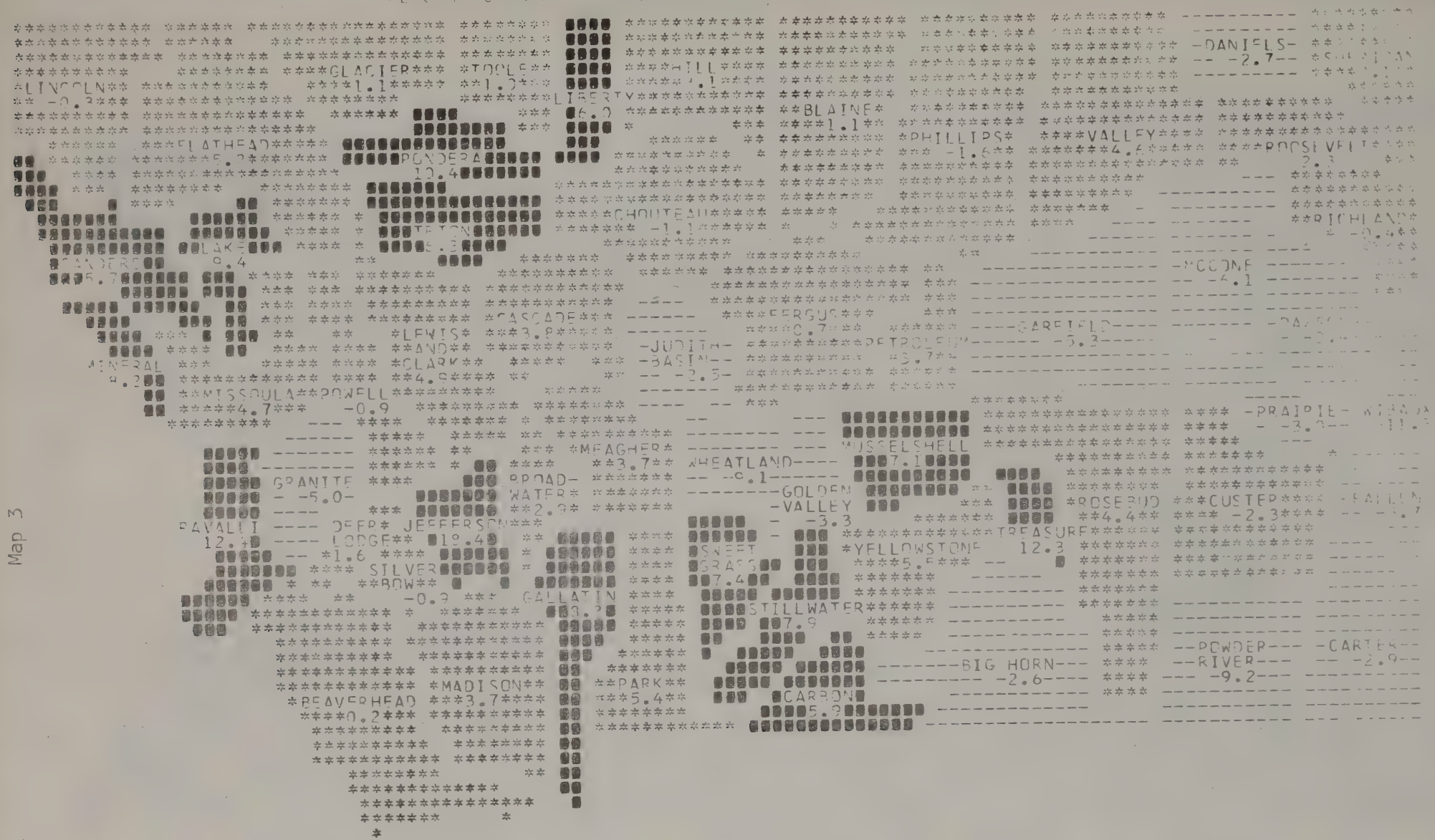
(PERSONS PER SQUARE MILE)



----	0.4 - 1.5	LOW QUARTILE
****	1.6 - 2.5	MEDIUM LOW QUARTILE
▒▒▒▒	2.6 - 4.3	MEDIUM HIGH QUARTILE
■■■■	4.7 - 58.7	HIGH QUARTILE

Map 2

F41



Map 3

F42

SOURCE: BUREAU OF THE CENSUS AND
BUREAU OF BUSINESS & ECONOMIC RESEARCH,
UNIVERSITY OF MONTANA.

----	-11.3 -	-2.4	LOW QUARTILE
****	-2.3 -	2.1	MEDIUM LOW QUARTILE
****	2.3 -	5.5	MEDIUM HIGH QUARTILE
####	5.7 -	18.4	HIGH QUARTILE

AGE-ADJUSTED DEATH RATES - MONTANA COUNTIES, 1969-71

BY PLACE OF RESIDENCE

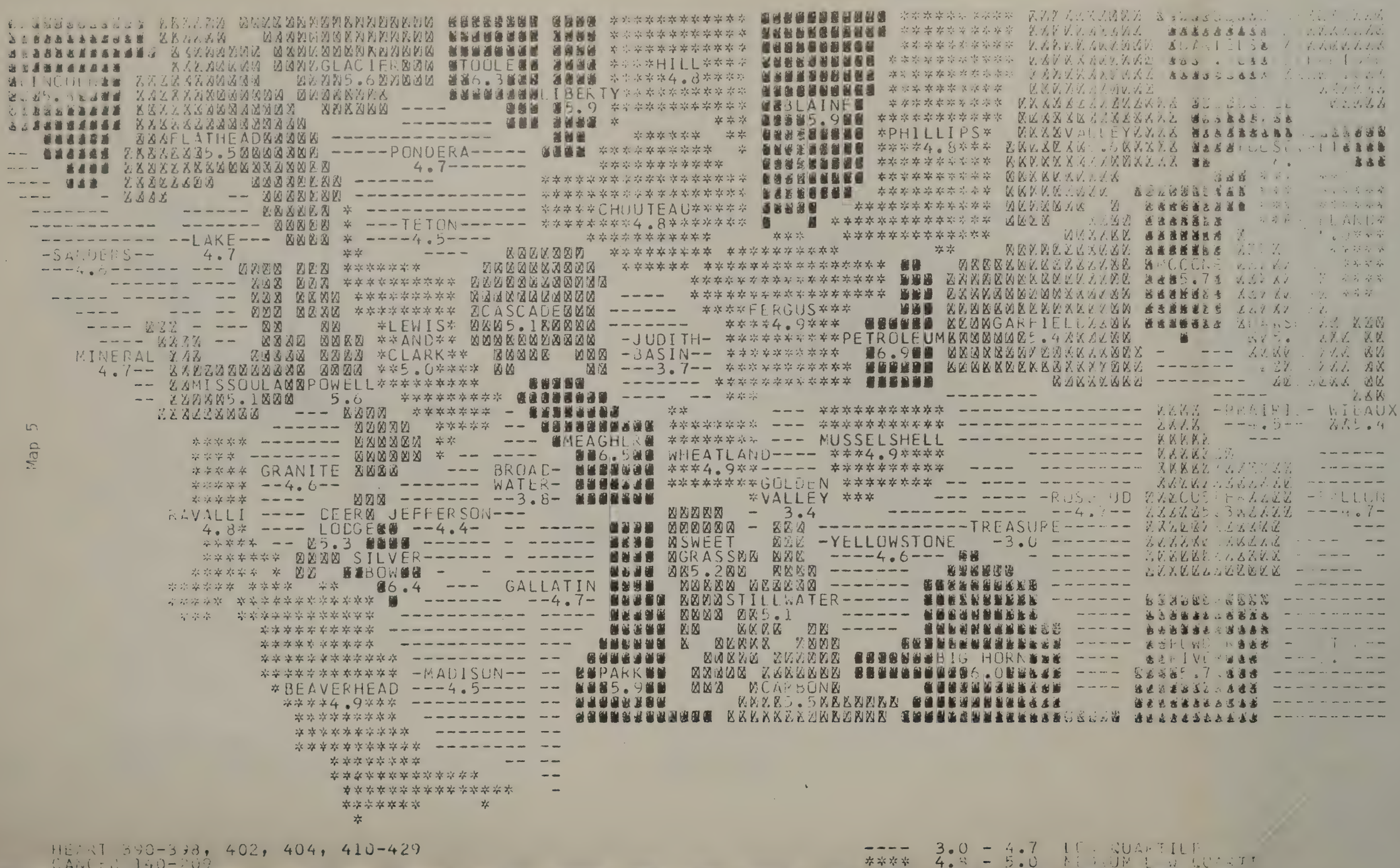
DEATHS PER 1,000 POPULATION.

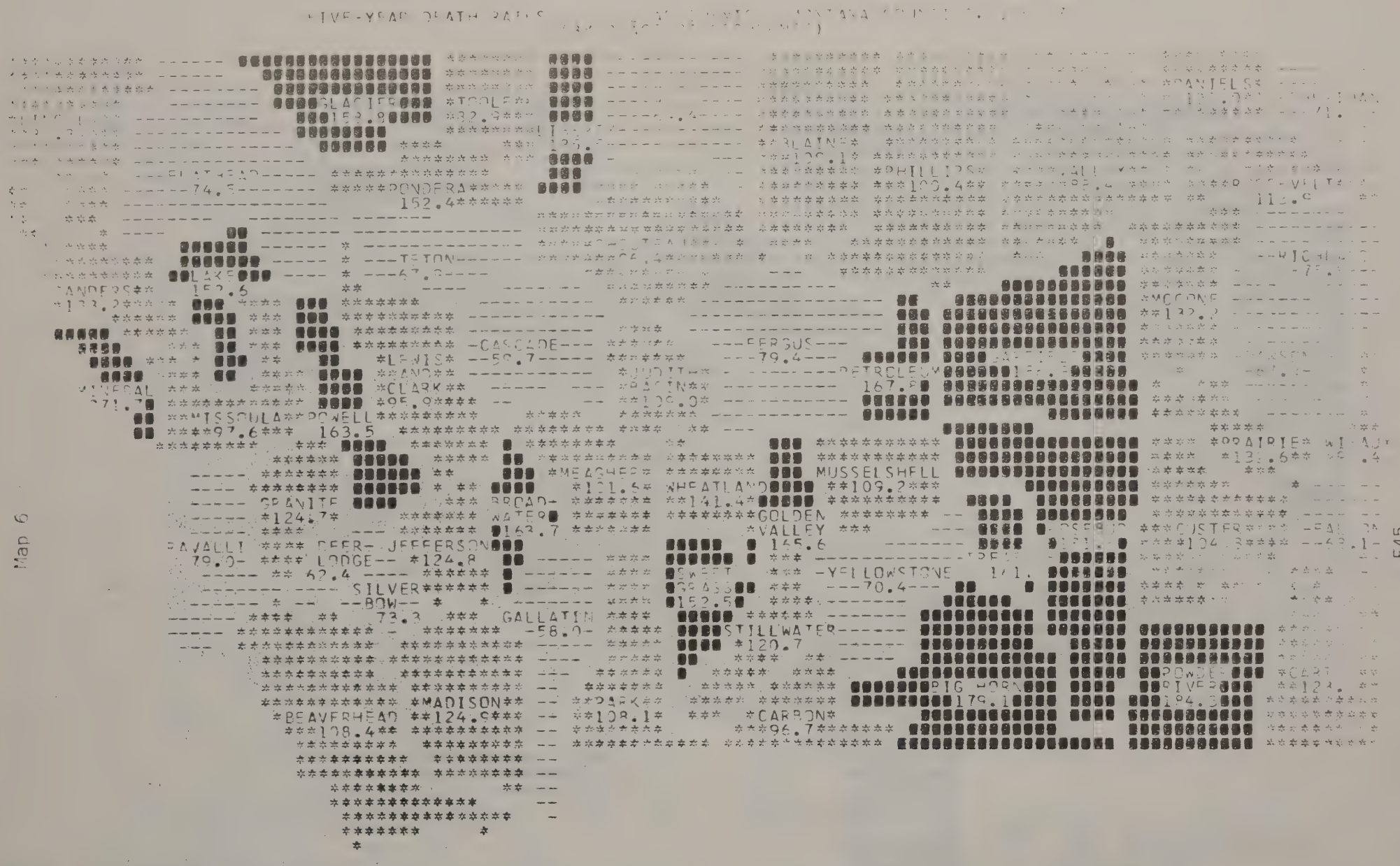
----	5.9 - 7.9	LOW QUARTILE
****	8.0 - 8.6	MEDIUM LOW QUARTILE
****	8.7 - 9.7	MEDIUM HIGH QUARTILE
****	9.8 - 11.6	HIGH QUARTILE

Map 4

F43

FIVE-YEAR AGE-ADJUSTED RESIDENT DEATH RATES FOR SELECTED
MONTANA, 1968-72





Map 6

F45

DEATHS PER 100,000 POPULATION.
EIGHTH REVISION ICDA RUBRICS 800-949.
SOURCE: STATE DEPT OF HEALTH & ENVIRONMENTAL SCIENCES.

----	58.0 - 79.4	LOW QUARTILE
****	82.3 - 108.4	MEDIUM LOW QUARTILE
****	109.0 - 152.4	MEDIUM HIGH QUARTILE
****	152.5 - 271.7	HIGH QUARTILE

[illegible]-YEAR DEATH RATES FOR CANCER OF THE UTERUS, MONTANA COUNTIES, 1968-72
(BY PLACE OF RESIDENCE)

DEATHS PER 100,[illegible] POPULATION.
EIGHTH [illegible]ISION [illegible] RATES 1970-1972.
SOURCE: [illegible] HEALTH & ENVIRONMENTAL SCIENCES.

----	0.0 - 1.7	LOW QUARTILE
****	2.7 - 4.7	MEDIUM LOW QUARTILE
****	5.0 - 7.3	MEDIUM HIGH QUARTILE
****	7.4 - 13.8	HIGH QUARTILE

FIVE-YEAR NEONATAL DEATH RATES - MONTANA COUNTIES, 1967-71

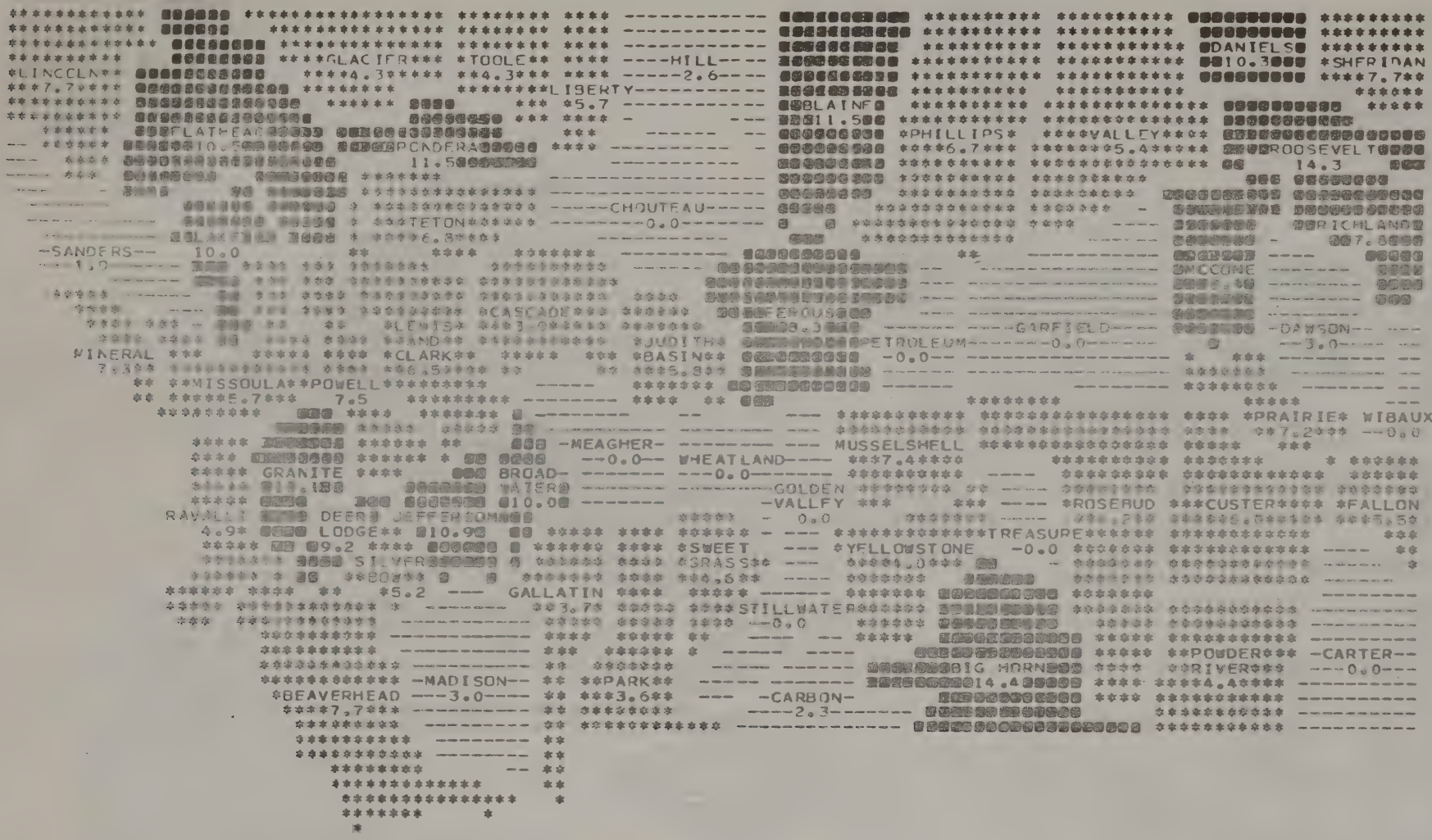
BY PLACE OF RESIDENCE

DEATHS UNDER 28 DAYS PER 1,000 LIVE BIRTHS.

----	0.0 - 11.4	LOW QUARTILE
****	11.5 - 15.2	MEDIUM LOW QUARTILE
****	15.4 - 19.0	MEDIUM HIGH QUARTILE
****	19.1 - 29.3	HIGH QUARTILE

FIVE-YEAR POSTNEONATAL DEATH RATES - MONTANA COUNTIES, 1967-71

BY PLACE OF RESIDENCE

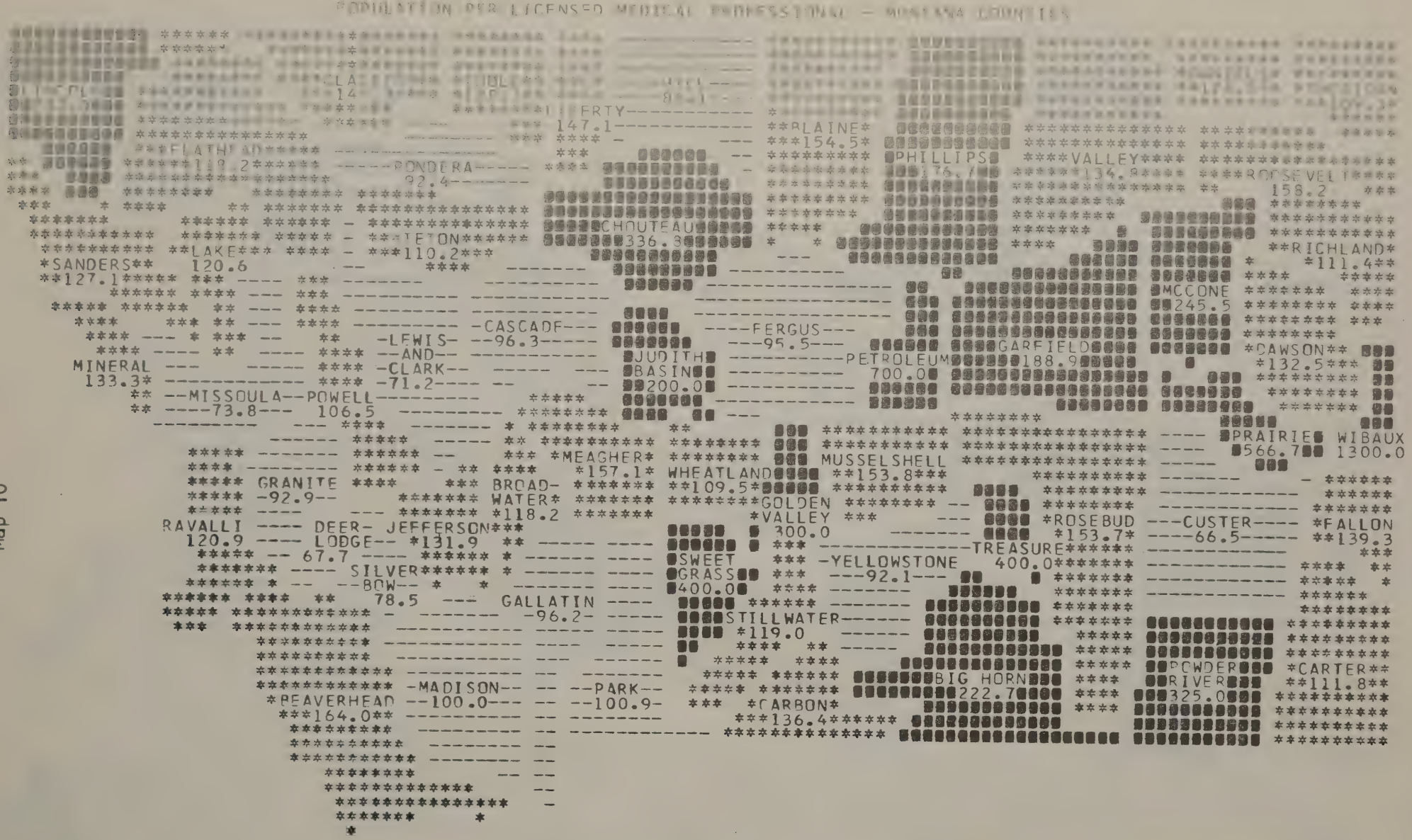


DEATHS FROM 28-365 DAYS PER 1,000 LIVE BIRTHS.

----	0.0 - 3.0	LOW QUARTILE
****	3.6 - 5.5	MEDIUM LOW QUARTILE
****	5.7 - 7.7	MEDIUM HIGH QUARTILE
****	7.8 - 18.1	HIGH QUARTILE

Map 9

F48



Map 10

F49

1972 ESTIMATED POPULATION.
NUMBER OF MEDICAL PROFESSIONALS LICENSED, JUNE 1973 (SOURCE: DEPT OF PROFESSIONAL & OCCUPATIONAL LICENSING).

----	66.5 -100.9	LOW QUARTILE
****	106.5 -131.9	MEDIUM LOW QUARTILE
****	132.5 -176.5	MEDIUM HIGH QUARTILE
■■■■	176.7 -*****	HIGH QUARTILE

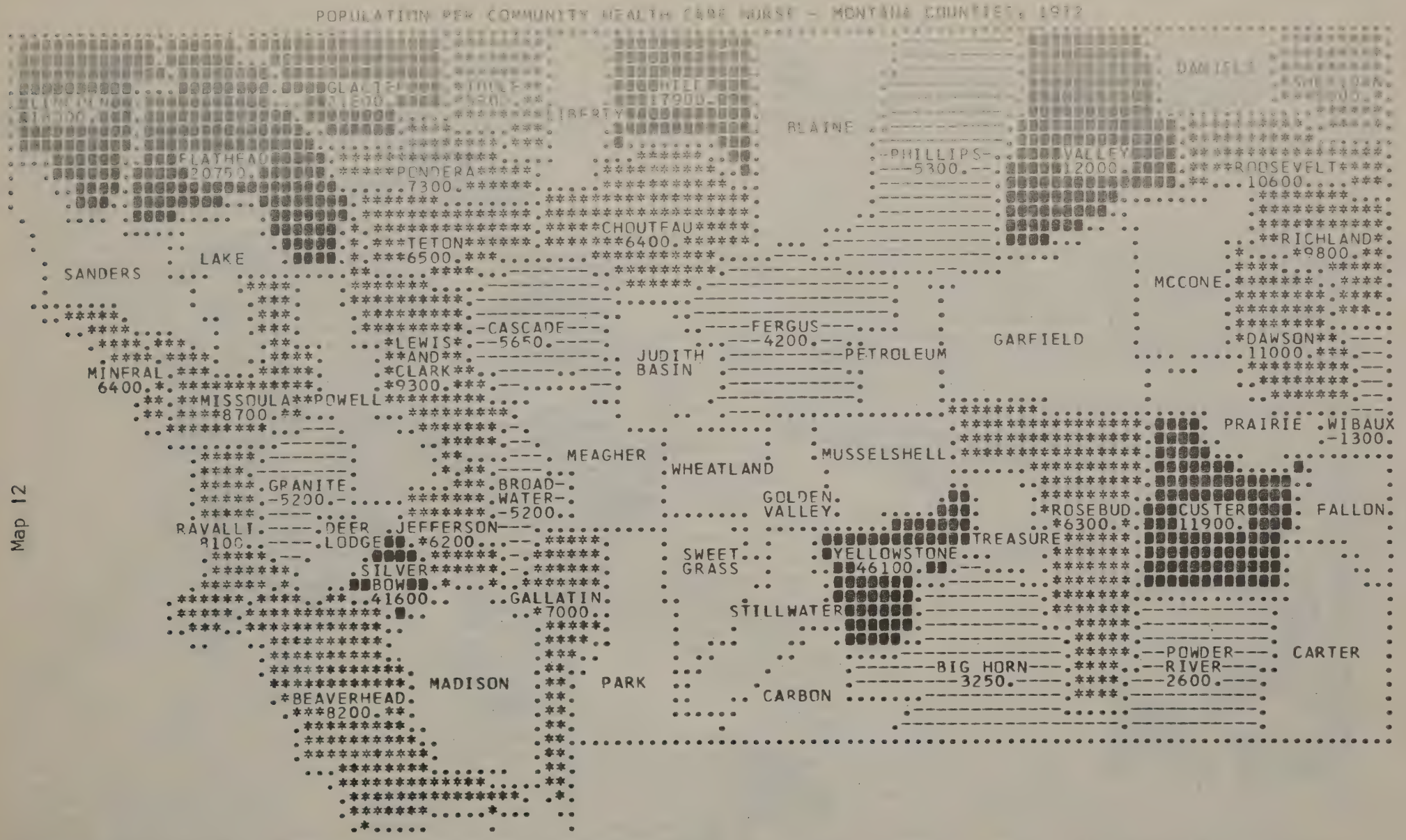
POPULATION PER LICENSED HOSPITAL AND NURSING HOME BED - MONTANA COUNTIES
(EXCLUDES STATE INSTITUTION BEDS)

1972 ESTIMATED POPULATION.
NUMBER OF HOSPITAL AND NURSING HOME BEDS, FEBRUARY 1974.
SOURCE: STATE DEPT OF HEALTH & ENVIRONMENTAL SCIENCES.

----	38.4 - 72.7	LOW QUARTILE
****	72.8 - 85.0	MEDIUM LOW QUARTILE
****	86.1 - 115.8	MEDIUM HIGH QUARTILE
■■■■	118.9 -2600.0	HIGH QUARTILE

Map 11

F50



Map 12

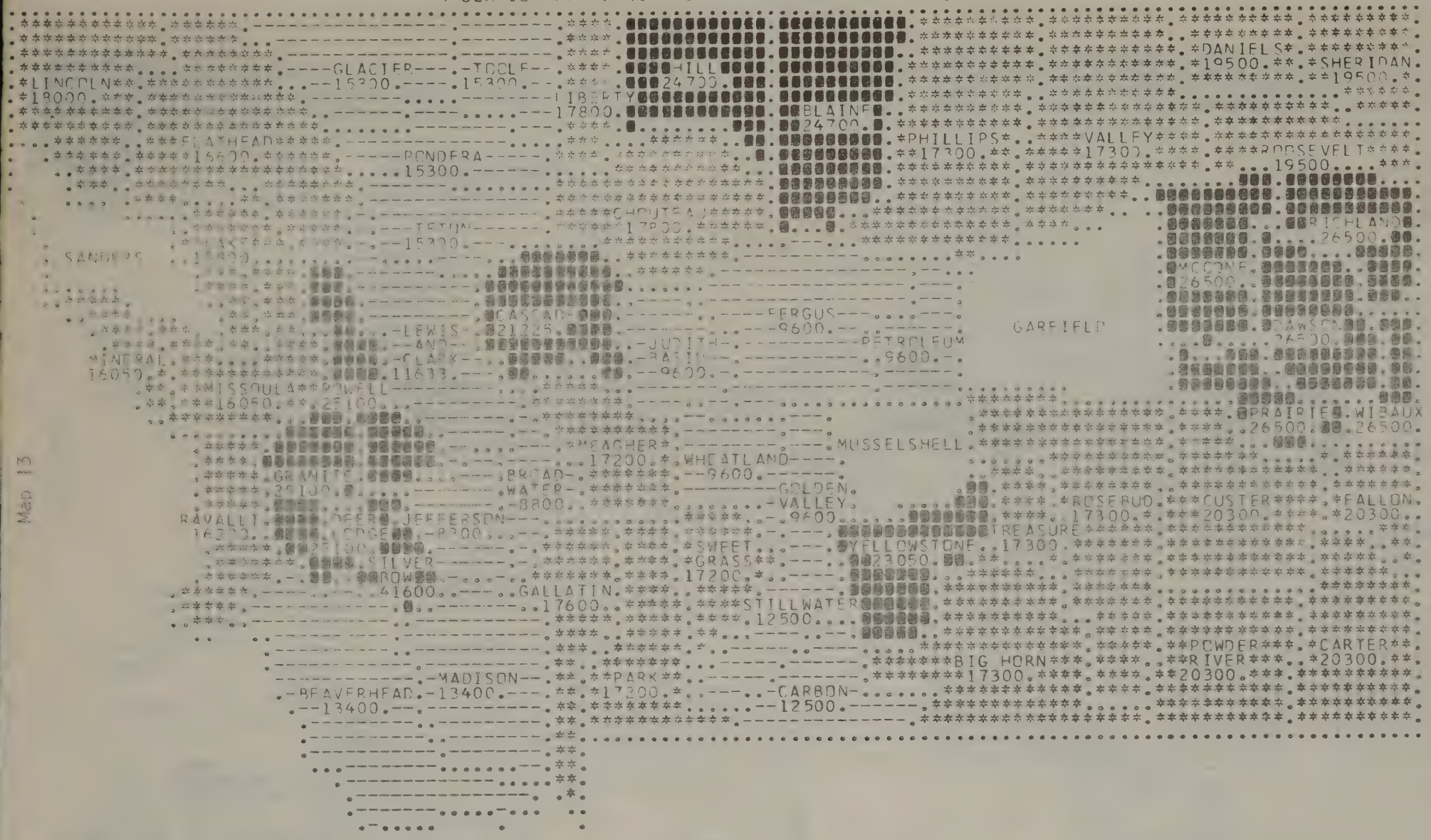
F51

UNSHADED COUNTIES ARE WITHOUT COMMUNITY HEALTH NURSES.

SOURCE: State Department of Health & Environmental Sciences
Bureau of Nursing

----	1300. - 5650.	LOW QUARTILE
****	5900. - 7000.	MEDIUM LOW QUARTILE
****	7300. - 11000.	MEDIUM HIGH QUARTILE
****	11900. - 46100.	HIGH QUARTILE

POPULATION PER SANITARIAN - MONTANA COUNTIES, 1972



Map 13

F52

UNSHADED COUNTIES ARE WITHOUT LOCAL SANITARIAN SERVICES.
SOURCE: STATE DEPT OF HEALTH & ENVIRONMENTAL SCIENCES.

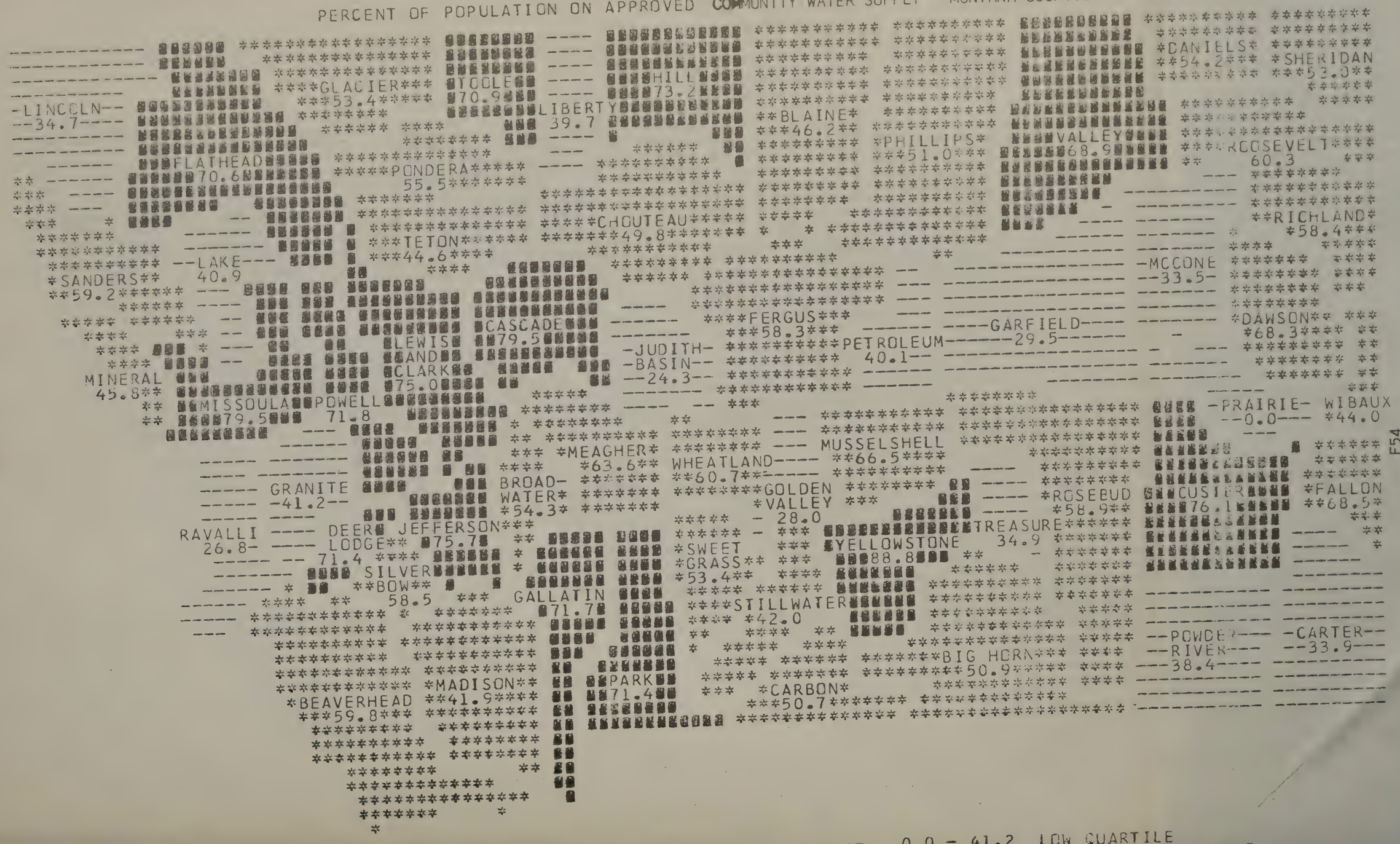
----	8800.	- 15300.	LOW QUARTILE
****	15800.	- 17300.	MEDIUM LOW QUARTILE
****	17600.	- 20300.	MEDIUM HIGH QUARTILE
■■■■	21225.	- 41600.	HIGH QUARTILE

PERCENT OF POPULATION WITH APPROVED REFUSE DISPOSAL - MONTANA COUNTIES

1970 POPULATION WITH APPROVED REFUSE DISPOSAL IN 1973.
SOURCE: STATE DEPT OF HEALTH & ENVIRONMENTAL SCIENCES.

----	0.0 - 0.0	LOW QUARTILE
****	15.6 - 53.4	MEDIUM LOW QUARTILE
****	54.1 - 76.9	MEDIUM HIGH QUARTILE
****	78.0 -100.0	HIGH QUARTILE

Map 15

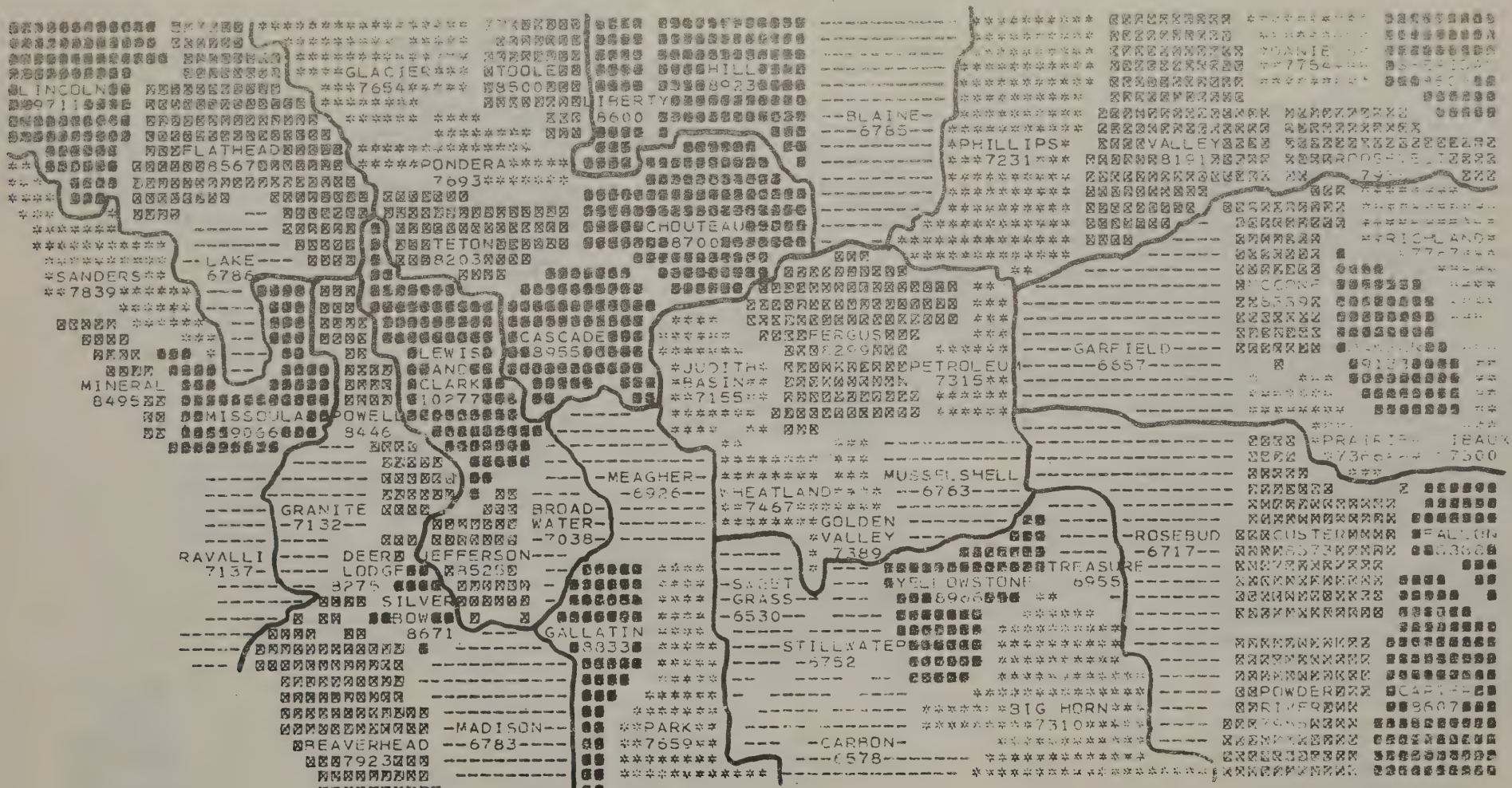

PERCENT OF POPULATION ON APPROVED COMMUNITY WATER SUPPLY - MONTANA COUNTIES
LINCOLN 34.7
FLATHEAD 70.6
GLACIER 53.4
TOOLE 70.9
LIBERTY 39.7
HILL 73.2
BLAINE 46.2
PHILLIPS 51.0
VALLEY 68.9
DANIELS 54.2
SHERIDAN 53.0
ROOSEVELT 60.3
RICHLAND 58.4
MCCONE 33.5
DAWSON 68.3
PRAIRIE 0.0
WIBAUX 44.0
FALLON 68.5
CUSTER 76.1
SANDERS 59.2
LAKE 40.9
PONDERA 55.5
TETON 44.6
CHOUTEAU 49.8
FERGUS 58.3
PETROLEUM 40.1
GARFIELD 29.5
MUSSELSHELL 66.5
ROSEBUD 58.9
MINERAL 45.8
MISSOULA 79.5
POWELL 71.8
CASCADE 79.5
LEWIS AND CLARK 75.0
JUDITH BASIN 24.3
WHEATLAND 60.7
MEAGHER 63.6
BROADWATER 54.3
GOLDEN VALLEY 28.0
TREASURE 34.9
YELLOWSTONE 88.8
GRANITE 41.2
RAVALLI 26.8
DEER LODGE 75.7
JEFFERSON 71.4
SILVER BOW 58.5
GALLATIN 71.7
SWEET GRASS 53.4
STILLWATER 42.0
BIG HORN 50.9
POWDER RIVER 38.4
CARTER 33.9
BEAVERHEAD 59.8
MADISON 41.9
PARK 71.4
CARBON 50.7
0.0 - 41.2 LOW QUARTILE
41.9 - 54.2 MEDIUM LOW QUARTILE
54.3 - 68.5 MEDIUM HIGH QUARTILE
POPULATION ON APPROVED WATER SUPPLY IN 1973.
ENVIRONMENTAL SCIENCES.

F54

STATE INFORMATION SYSTEM
MONTANA DEPARTMENT OF PLANNING AND ECONOMIC DEVELOPMENT - CAPITOL STATION, HELENA, MT

MEDIAN FAMILY INCOME IN MONTANA COUNTIES, 1969

with Multi-County Districts



Map 16

F55

1964 U.S. CENSUS ECON. PC(1)-C28.

STATE INFORMATION SYSTEM
MONTANA DEPARTMENT OF PLANNING AND ECONOMIC DEVELOPMENT - CAPITOL STATION, HELENA, MONTANA 59601

PER-CAPITA INCOME I. MONTANA COUNTIES, 1969

Map 17

F56

U.S. DEPT. OF COMMERCE BUR. OF THE CENSUS

----	2102 - 2347	LOW QUARTILE
****	2362 - 2454	MEDIUM LOW QUARTILE
▒▒▒▒	2576 - 2819	MEDIUM HIGH QUARTILE
▓▓▓▓	2830 - 3261	HIGH QUARTILE

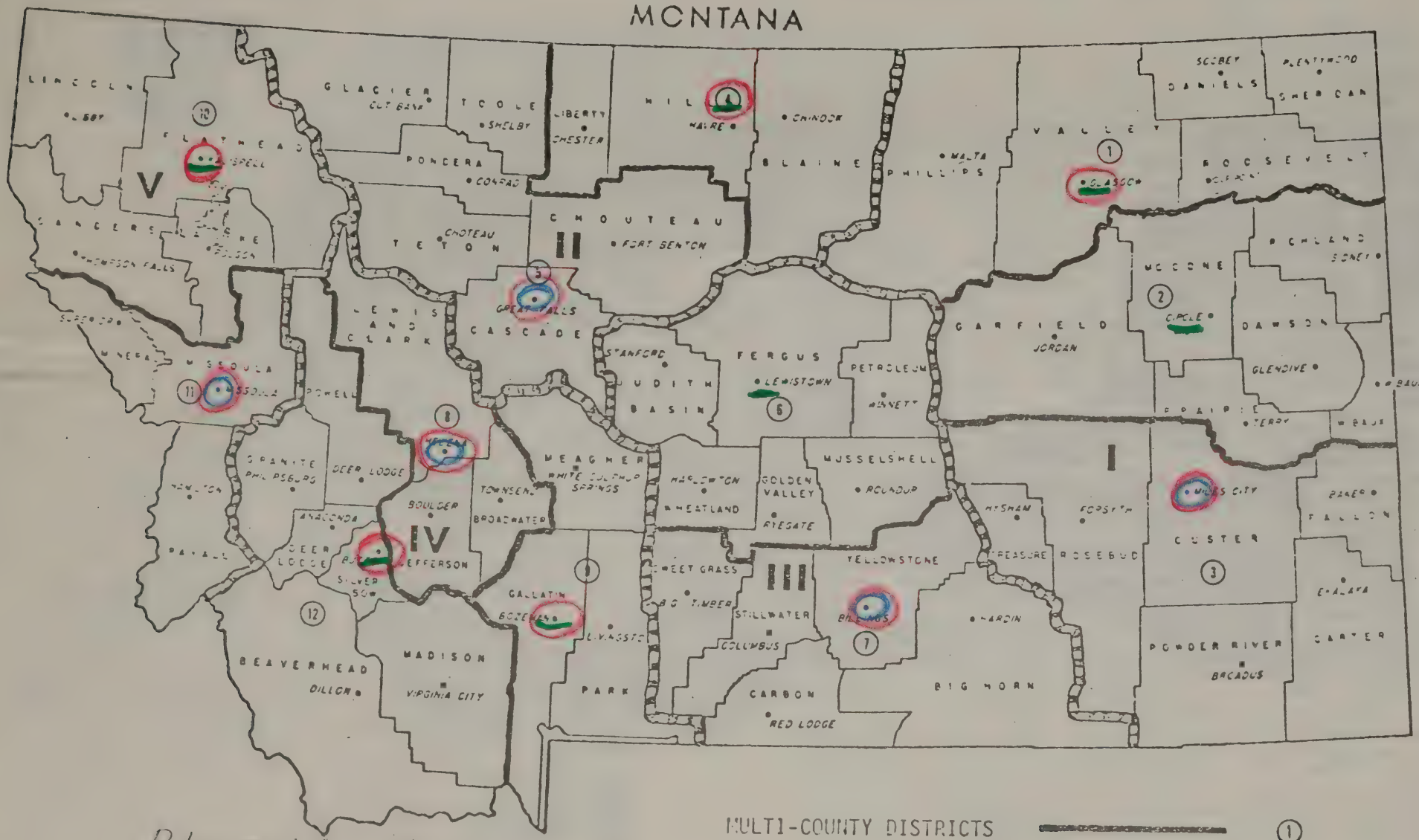
TAXABLE VALUATION PER CAPITA - MONTANA COUNTIES

Map 18

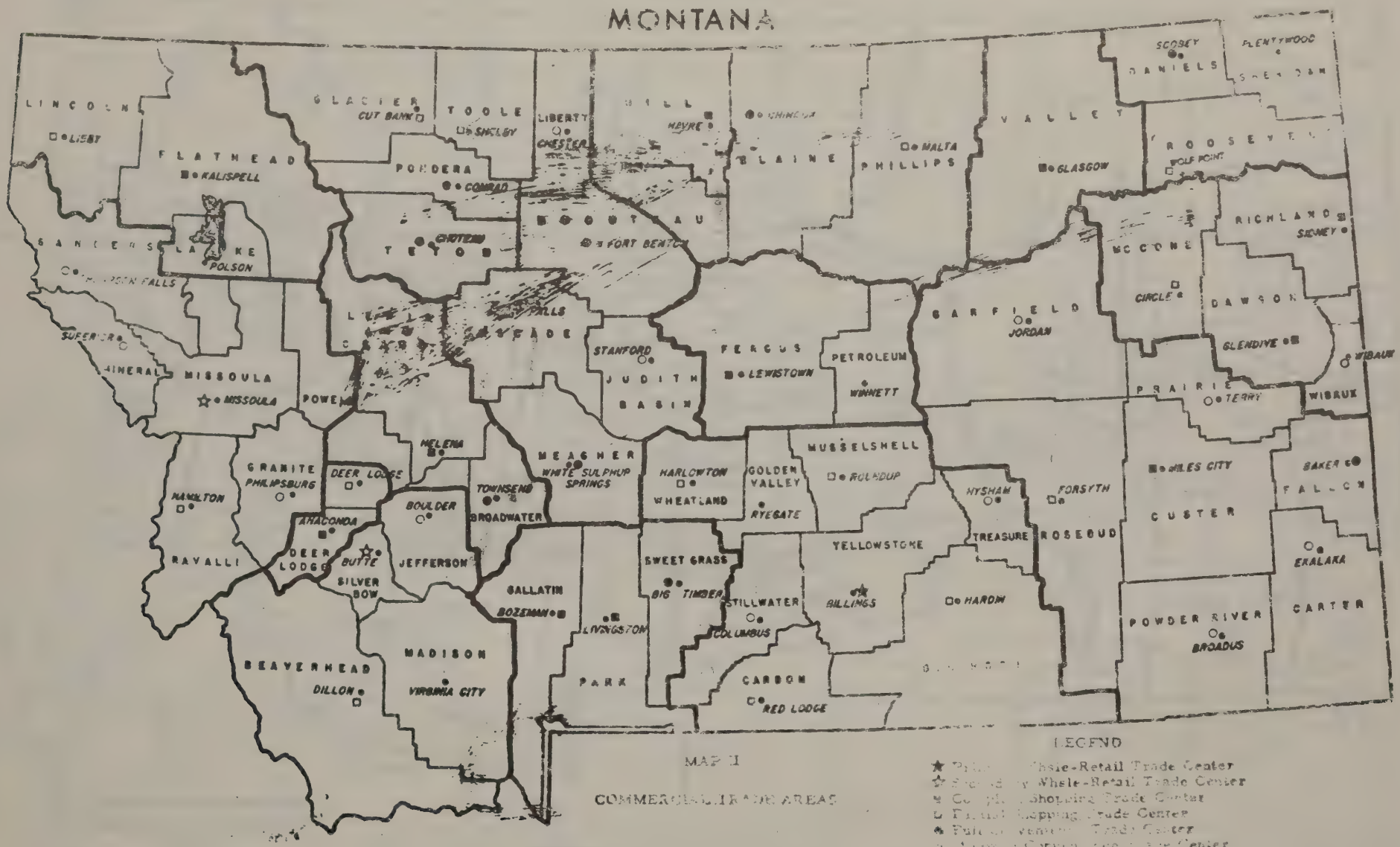
F57

1972 ESTIMATED POPULATION.
1972-73 TAXABLE VALUATION (SOURCE: 25TH BIENNIAL REPORT OF THE MONTANA STATE BOARD OF EQUALIZATION).

----	919. - 1207.	LOW QUARTILE
****	1246. - 1900.	MEDIUM LOW QUARTILE
****	1969. - 2259.	MEDIUM HIGH QUARTILE
■■■■	2455. - 6427.	HIGH QUARTILE



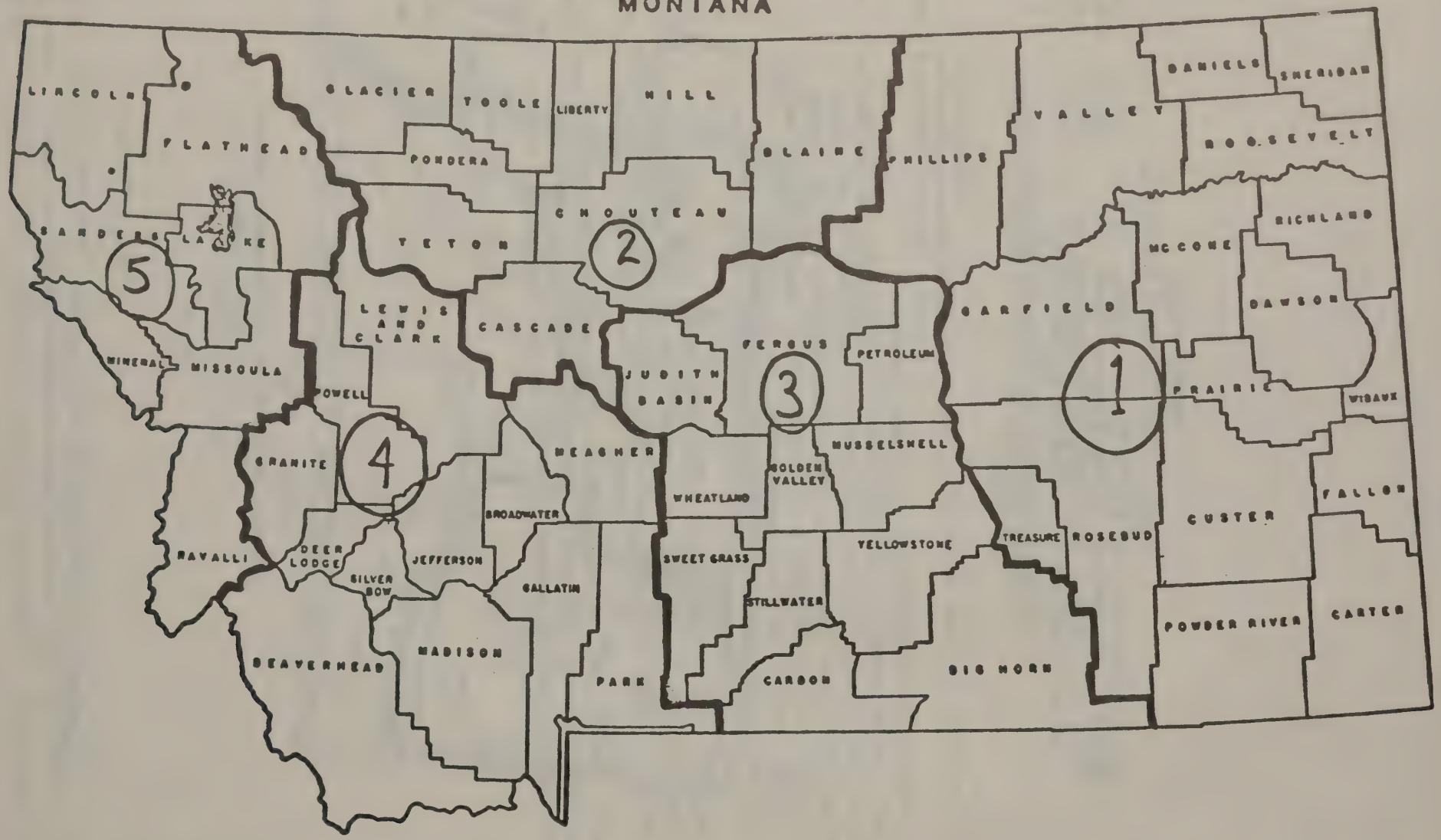
Blue - Adm. Areas
Red - Ten Hlth Depts - Proposed Regions
Green - Satellites in Districts
(Relate to Adm. Areas)


MONTANA
LINCOLN
LIBBY
FLATHEAD
KALISPELL
GLACIER
CUT BANK
TOOLE
SHELBY
LIBERTY
CHESTER
HILL
HAVRE
CHINOOK
BLAINE
MALTA
PHILLIPS
VALLEY
GLASGOW
SCOBEY
DANIELS
PLENTYWOOD
SHERIDAN
ROOSEVELT
WOLF POINT
PONDERA
CONRAD
TETON
CHOTEAU
FORT BENTON
SANDERS
LAKE
POLSON
RICHLAND
SIDNEY
MCCONE
CIRCLE
DAWSON
GLENDIVE
WIBAUX
SUPERIOR
MINERAL
MISSOULA
POWELL
LEWIS AND CLARK
CASCADE
FALLS
STANFORD
JUDITH BASIN
FERGUS
LEWISTOWN
PETROLEUM
WINNETT
GARFIELD
JORDAN
PRAIRIE
TERRY
WIBAUX
HELENA
MEAGHER
WHITE SULPHUR SPRINGS
HARLOWTON
WHEATLAND
GOLDEN VALLEY
MUSSELSHELL
ROUNDUP
GRANITE
PHILIPSBURG
DEER LODGE
TOWNSEND
BROADWATER
RYEGATE
HYSHAM
FORSYTH
MILES CITY
CUSTER
BAKER
FALLON
HAMILTON
RAVALLI
ANACONDA
BOULDER
DEER LODGE
BUTTE
SILVER BOW
JEFFERSON
SWEET GRASS
BIG TIMBER
YELLOWSTONE
BILLINGS
TREASURE
ROSEBUD
HARDIN
EKALAKA
CARTER
GALLATIN
BOZEMAN
LIVINGSTON
STILLWATER
COLUMBUS
POWDER RIVER
BROADUS
BEAVERHEAD
DILLON
MADISON
VIRGINIA CITY
PARK
CARBON
RED LODGE
LEGEND
MAP I
COMMERCIAL TRADE AREAS
SOURCE: Trade Centers of the Upper Midwest
Upper Midwest Research Council.

Map 21

LEGISLATIVE DISTRICTS

MONTANA



Map 22

F61

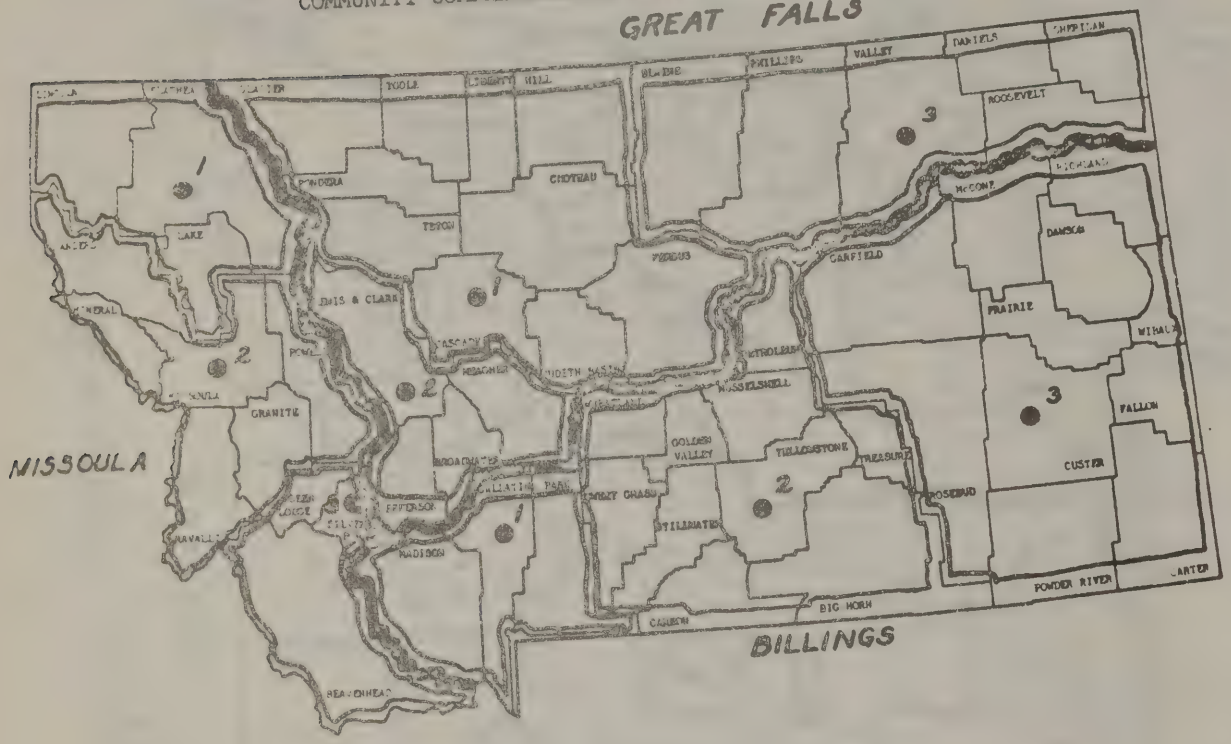
No. 1050 — County Outline Map
STATE PUBLISHING COMPANY
Helena
80 Pads - E - WY

1-Eastern Region, Rich Eudy, 151-482-3374
2-North Central Montana Health Planning Council, Levi Taft, 151-434-2462
3-South Central Regional Health Planning Council, Jim Toner, 122-253-3851
4-South Western Areawide Health Planning Council, Jim Foley, 449-2825
5-Northwestern Areawide Health Planning Council, Ed Mahn, 125-5438271

A Montana Plan for Mental Health Services prepared by Statewide and Community Mental Health Planning Committee. June 30, 1965

MAP 9.1

AREA DELINEATION FOR
MENTAL HYGIENE CLINICS AND
COMMUNITY COMPREHENSIVE MENTAL HEALTH DISTRICTS



——— = Delineation areas for clinics

▬▬ = Delineation areas for community comprehensive mental health center districts

COMMUNITY COMPREHENSIVE MENTAL HEALTH CENTER DISTRICTS

A. MISSOULA - 207,331
1. Kalispell - 58,606
2. Missoula - 76,937
3. Butte - 72,288

B. GREAT FALLS - 244,428
1. Great Falls - 153,563
2. Helena - 37,723
3. Glasgow - 53,142

C. BILLINGS - 222,461
1. Bozeman - 44,424
2. Billings - 117,512
3. Miles City - 60,525

TOTAL - 674,720

The Big Sky Country

MONTANA STATE SENATE

Room 428A
State Capitol
Helena 59601

July 19, 1973

Dear Doctor:

In connection with a study of public health services in Montana, our committee would very much appreciate obtaining some information from you concerning the delivery of public health services in your state.

We would like to request that you or a member of your staff complete and return the enclosed questionnaire. We believe having the benefit of your experience in this area will be of great help to us.

Our study will primarily encompass the subjects of, 1) a minimum level of public health services to be provided; and 2) the feasibility of establishing district, as opposed to city or county, health departments. However, we do anticipate that other aspects of the delivery of public health services will arise during the course of the study, thus, even if you do not have a system of district health departments, we would appreciate completion and return of the questionnaire.

Thank you in advance for your assistance and cooperation.

Sincerely,

Elizabeth Richter
Legislative Assistant
Interim Public Health Committee

er
Enclosure

PUBLIC HEALTH SERVICES QUESTIONNAIRE SENT TO FOLLOWING STATES 7/19/73:

Alaska

Arizona*

Arkansas*

California*

Colorado*

Idaho

Iowa*

Kansas*

Louisiana*

Minnesota*

Missouri

Nebraska*

Nevada

New Mexico

North Dakota*

Oklahoma*

Oregon*

South Dakota

Texas*

Utah*

Washington*

Wyoming

* Completed and returned questionnaire

Is There a Future for Local Health Departments?

JOHN J. HANLON, MD

Dr. Hanlon is Assistant Surgeon General and Coordinator for Public Health Programs. *The paper is based on speeches he gave at the annual meetings of the National Association of Counties in Dallas, Tex., on July 23, 1973, and the Texas Gulf Coast Public Health Association in Galveston on September 21, 1973. Tearsheet requests to John J. Hanlon, M.D., Room 18A-30, Parklawn Bldg., 5600 Fishers Lane, Rockville, Md. 20852.*

THE FIRST SEAL of the American Public Health Association depicted and stated the biblical phrase, "And the leaves of the tree were for the healing of the nations" (Revelation 22:2). The seal was changed several years ago to something that looks like a wheel with big teeth. Maybe this symbol is appropriate—perhaps the change represents a subconscious feeling that the public health profession is caught in the gears of social change. Indeed, the way things often seem, I venture to suggest another change in our professional heraldic symbol—a crossed broom and shovel rampant on a worn but comfortable bed of straw, since instead of proudly carrying the flag at the head of society's troops and resources, increasingly we seem content to trail along at the tail end of the parade, catching the droppings and leavings of others.

The results of the efforts of earlier public health workers were truly remarkable, especially when one considers the pathetic paucity of their resources. But we are not justified in merely taking credit for accomplishments while at the same time we back away from our responsibilities and opportunities to help solve some of the consequences of our actions. Something unhealthy seems to have happened of late to public health. We seem caught in the doldrums or in some kind of professional Sargasso Sea. This lassitude is evidenced by the titles of numerous conferences and presentations—titles such as "Where Are We Going in Public Health?" "Are Health Departments Really Necessary?" and my topic, "Is There a Future for Local Health Departments?" But we must do more than voice collective concern and wring our hands. This introspection, of course, is not necessarily all bad, provided it leads to intelligent adaptation and action.

A common and popular form of response is reorganization, and obviously a great many outdated and creaky organizations cry for adjustment. However, mere reorganization of the formal structure of an agency will not in itself produce improved public service. Reorganization alone can merely remove some of the barriers to the provision of a balanced, efficient, and effective service and create a framework in which those with varied but pertinent skills may find it easier to collaborate to help those in need.

The necessary companion to reorganization is operational integration. In the sense in which I use the term, operational integration is the real test of the success of reorganization. It results from deep and profound attitudinal changes, changes which are much more difficult to effect than the task of making changes in a formal organization.

It is never easy or comfortable to cast out the old and ring in the new. Physicians, nurses, environmental personnel, administrators, and others must be persuaded to broaden their horizons, to let their imaginations, interests, and courage soar away from their existing philosophic and professional restraints so that they view the public's health problems and needs in the total context and can then consider solutions from this new perspective. Only with a changed perspective can we achieve the 200-year-old constitutional goal of equality of health opportunity for all citizens without reference to age, sex, race, creed, or station in life. It is well, in this regard, to remind ourselves that the Constitution of the United States proposed to guarantee only three things—life, liberty, and the pursuit of happiness—and health is critical to the achievement of each of them.

The Rationale for Change

How do these thoughts relate to the future of local health departments? With reference to organization on the one hand and constitutional commitment on the other, it is obvious that we cannot hope to provide equitable health opportunity as a human right to all of our people as long as public health activities in our States and localities are organized along the lines of the pre-World War I Balkans. We simply have to pull ourselves together. In the course of working on all levels of government, I have long been deeply troubled by the extent of pernicious and destructive jealousy, distrust, provincialism, status consciousness, competition, and, above all, inadequate communication that has been allowed to exist within organizations on each level of government and among the several levels of government. The confusing and inefficient plethora of conflicting, hence ineffective, in toto policies, ordinances, programs, and so forth is the bitter price the public pays.

In the name of heaven, humanity, and health, why should the State or community a person lives in determine what life-preserving services he is entitled to, are available, or under what conditions? Our present situation is little short of indecent and inequitable chaos. And part of the fault is ours. Not many of us, I fear, have sufficient conviction, idealism, and courage to provide the social leadership which, after all, is our mandated responsibility. Hence I suggest the bed of straw on our heraldic shield.

All these shortcomings imply a need to change our priorities, our relationships, our way of doing things—which is another way of saying we have to change our role. We have gone through a substantial period during which the philosophy for our programs has been based, with considerable justification, upon the concept that we should do things that no one else could do, that no one else wanted to do, that no one else could in our view be trusted to do, and largely for components of society with which no one else wanted to be bothered—indigents, certain ethnic groups, and persons with difficult or unpleasant problems such as alcoholism, venereal disease, geriatrics, and chronic mental illness.

But now in the late 20th century we must recognize that we have entered quite a different period of public health and social history and development, a period when such a philosophy no longer is valid. We must learn to join and to work with the many forces and components of the total community toward the assurance of total health care for the total people to an extent far beyond that to which we have been accustomed and with which we felt comfortable. We must seek partners in these endeavors and we must, by various means, make certain that we in turn are dealt in as partners in any game in which we should play a part. By doing so, we will maximize understanding and support, minimize opposition, achieve more for our communities, while retaining and enforcing our credibility and appropriate impartiality. We need to realize that we are expending much time, money, and effort in doing outdated things or things more appropriate for others to do. The price paid for not accepting this concept is failure to take our place in the future—which is now.

There is no longer any question that truly comprehensive health services will soon be made available to the American people. I do not foresee a single monolithic approach. The approach will probably involve a combination of means and

methods. Whatever forms evolve, it will be necessary to pull together or at least closely interrelate the resources and activities of a variety of institutions—private and public medical practice, hospitals, the various insurance mechanisms—and health departments. This network poses the most critical question for the health department. Is it going to carry the flag in this endeavor, or is it going to follow with a broom and shovel? Let's examine what is involved in the answer.

Local public health programs had their genesis partly in safe milk programs for children of the poor. Subsequently these developed into so-called well-child clinics and prenatal and postnatal services for the disadvantaged. Similarly, widespread communicable diseases led to the development of health immunization clinics, as well as early diagnosis and treatment of such conditions as tuberculosis and venereal diseases, again largely for those unable to pay.

Antedating even these activities, many local public health agencies had to fill a vacuum in welfare services by operating public hospitals, custodial institutions, and even poor farms. Thus, over the years the governmental agencies responsible for the protection and promotion of the health of all of the people were essentially trapped into providing direct personal services to a limited segment of the population. Furthermore, the very nature and complexity implicit in providing direct services to this component of the population limit severely the time and energy which public health personnel can devote to broader considerations that, in the long run, are of greater consequence to the entire population. Beyond this limitation, there is good evidence that continuing down this path tends to isolate the poor further and to make them even more dependent. Public health officials who become enmeshed in such functions sometimes tend to develop a sort of spurious satisfaction and sense of security, based perhaps on a feeling of clinical and political fulfillment.

Using Nongovernmental Resources

The question then is: Are these legitimate and fruitful functions of a public health department at this point in time? Andrew Carnegie, when asked to what he attributed his phenomenal success, replied that he had long made it a rule never to do anything himself that he could employ someone else to do as well or better. This concept is pertinent to a valid answer to the question confronting us. There exist in any community many nongovernmental forces and resources which can and do contribute significantly and critically to the solution of public and social problems, including those which relate to health. Many of them can do so as successfully and efficiently or more so than the public health agency. Furthermore, the alienation, isolation, and pauperization of certain people and groups tend to be minimized when nongovernmental forces are involved.

Why not, therefore, leave the provision of most direct personal health services, preventive as well as therapeutic, to those persons and institutions that are most suitable and best equipped to do so? Among these providers are physicians who practice individually or in groups, the other professions and the technicians related to them, and the private hospitals, clinics, and similar health institutions. Government, and especially health departments, would be well advised to remove themselves from the operation of institutions such as hospitals and clinics, especially now that widespread cost coverage is available through public and private health insurance.

Typically, public hospitals must accept all who come to their doors, and the majority of their patients are the socially and economically underprivileged and the transient, who contribute little or nothing toward the cost of their care. Public appropriations must provide most of the necessary funds; hence, the quality and availability of personnel and material resources tend to be affected by economic fluctuations. To compound the situation, during periods of economic slump, the demand placed upon the public institution increases while its ability to meet the demand declines. In addition, if a unit of government is engaged in operations that are shared or duplicated by the private sector, and that it must supervise to any degree, the governmental unit is placed in the untenable position of conflict of interest and the risk either of upholding hypocritical double standards or noncompliance with its own standards.

What I am suggesting is a policy of using nongovernmental institutions to the maximum feasible extent to achieve governmentally determined objectives. One of the premises of this policy is that government is not, and probably never can be, a truly efficient operator-manager because of the nature of the fluctuating demands placed upon

it and the diverse forces which determine its structure and function.

As a consequence, rather than attempting to provide personal services, the official health agency might better concentrate upon its important and unique potential as community health conscience and leader. Governmental agencies, such as local departments of public health, are in the best position to sense the need for and to promote the establishment of social policy. In their turn, the nongovernmental institutions of society should (*a*) implement these policies, (*b*) establish necessary institutions, and (*c*) provide the needed services. In the process, the nongovernmental agencies may be assisted financially or otherwise by government through subsidies, loans, payment of fees for service, training, equipment, or a variety of other means.

Health Department—Leader and Conscience

What does this allocation of responsibilities leave for the health department? If nothing else, the department should and must serve as the diagnostician of the community as a whole. To do so, the department's most basic function relates to health program data and information—its generation, collection, coordination, analysis, and dissemination. Out of this function, it derives its next basic role—critical assessment of present and potential community health problems and of factors in other fields that may relate to or affect them, stimulation of action by whoever may be of assistance, and evaluation of what is done. Note that important throughout these functions is the development of a network of effective alliances.

The health department's administrators should bear in mind that no end-point may be visualized, either in relation to scientific and technical advances and potentials in the health and medical field or in the extent to which this field may be a significant political issue. Current events provide ample substantiation of this situation. Here again is evidence of the necessity for community health statesmanship, certainly a basic responsibility of the local health department. In the near future, major emphasis must be placed upon early detection and treatment aimed at circumventing the progressive development of disease—primary prevention, health maintenance, and health promotion. It is the health department which should serve as the community catalyst and bridge between the public with the need and the complex of the community's health resources with the solution.

Another important problem to be considered is that it is unrealistic to expect people to forego readily present needs, pleasures, comforts, and conveniences for future safety and health security. A tremendous and continuous educational and perhaps propaganda effort is necessary. While, as with all other community health efforts, many professions and organizations should participate in this effort, the major broad responsibility again rests with the official health agency.

There is no lack of important roles, functions, and responsibilities for a progressive local health department, provided it is not burdened by institutional operations. Some of these roles follow:

—To serve as the community health conscience, the community health analyst, the community health counselor, and the community health catalyst.

—To become a key component of community health planning

—To participate in the development of community health policy

—To develop health criteria, standards, and qualifications

—To promote necessary health legislation

—To work with other components of local government whose work or resources may affect community health

—To lead with new techniques, programs, and alignments

—To conduct or promote research and demonstration in health program management, manpower development and use, clinical medicine, and the like

—To insure involvement of community groups and the public in the decision-making process

—To coordinate the efforts of various health resources in the community

—To maintain surveillance over the activities of private or public agencies or institutions which may affect the public's health

—To educate all components of society—the public, professions, business and industry, elected officials and others—in the fundamentals of community health.

This list, of course, is not comprehensive, but if these roles are adequately served, the local health department need not fear the lack of constituency for support; its constituency will consist of practically the entire community.

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